Community Health, Inc.

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May 25, 2010

Craig Smith, Section Chief
Certificate of Need Section
Division of Health Service Regulations
Department of Health and Human Services
703 Barbour Drive
Raleigh, N.C., 27603

Dear Mr. Smith:

In accordance with N.C. GEN. STAT. §. 131E-185(al)(1), Community Home Health of North Carolina, LLC ("Community") hereby submits the following comments related to competing applications to establish a Medicare/Medicaid Certified Home Health Agency in Wake County. Pursuant to relevant statutory criteria, Community's comments include discussion and analysis regarding whether, in light of the material contained in the applications and other relevant factual material, the. applications comply with the relevant review criteria, plans and standards." See N.C. GEN. STAT. § 131E-185(al)(1)(c). The applications on which we offer comments are:

J-8506-10 AssistedCare Home Health, Inc.

J-8507-10 ARC Therapy Services, LLC

J-8508-10 SunCrest Home Health of North Carolina, Inc.

J-8509-10 Home Health and Hospice Care, Inc.

J-8511-10 United Home Care, Inc.

J-8512-10 Continuum II Home Care and Hospice, Inc.

Our comments are organized to first address two major issues that apply to several of the competing applications and then to provide separate comments on each of the competing applications.

Based on Community's review of the applications, the application submitted by Community is the only one that fully conforms with the relevant review criteria, plans and standards. Additionally, Community demonstrated in its application that it has the experience, community relationships, resources, and understanding of the state and federal regulatory process to successfully establish a Home Health Agency in Wake County and to meet the unmet needs of county residents.

We appreciate your consideration of our application and of these comments.

Sincerely,

C. Saunders Roberson, Jr.
President
Community Health, Inc.
(Sole Owner of Community Home Health of North Carolina, LLC)

Competitive Comments on Applications for a Medicare-Certified Home Health Agency in Wake County Pursuant to the 2010 North Carolina State Medical Facilities Plan

Submitted by
Community Health, Inc.
On behalf of
Community Home Health of North Carolina, Inc.

GENERAL COMMENTS

1. Community Health Inc. ("Community") is the sole shareholder of the applicant Community Home Health of North Carolina, Inc. ("CHHNC") and submits these comments on behalf of CHHNC. There are seven competitive applicants for a Certificate of Need (CON) for a Medicare-certified Home Health Agency in Wake County. Only one CON may be awarded so Division of Health Services Regulation ("DHSR") must compare the applications and select the application that best conforms to the general CON statutory review criteria and to the specific regulatory criteria and standards applicable to home health agencies.

2. Community has reviewed all the applications and thinks that the information in the record shows that the CHHNC application best conforms to the criteria and standards and does the most to improve access to Medicare-certified home health services for residents of Wake County. These comments are organized as follows. There are three issues that affect multiple applications in the batch: (1) unreasonable assumptions on the time required for Medicare certification, (2) unnecessary duplication of authority to provide Medicare-certified home health services in Wake County, and (3) representations about psychiatric home health services. These issues are discussed first. The comments then address each applicant individually. We conclude with a discussion of why CHHNC is the superior applicant.

3. At this time the information Community has on each application is limited to the four corners of each application, including its exhibits and attachments. In some cases that information appears sufficient to say there is a significant deficiency in one or more applications. In other cases the information is only sufficient to raise a question about an application. We must trust that DHSR staff will arrive at the correct answers to these questions as they review the applications.

TIME REQUIRED FOR MEDICARE CERTIFICATION

4. The time between state licensure and Medicare certification is a critical period in the development and operation of a Medicare-certified home health agency ("HHA"). The reason organizations seek this certification is because about 70 percent of the revenue of a HHA comes from Medicare or Medicaid. Until a HHA successfully becomes Medicare certified and enters into a provider agreement with the Medicare

program and receives a Medicare Provider Number ("MPN") it cannot bill and receive payment for services furnished to Medicare beneficiaries. Likewise, until Medicare certified, a HHA cannot enroll in the Medicaid program or bill and collect for services rendered to Medicaid enrollees. Some commercial managed care plans also look to Medicare-certification as a criterion in determining whether to contract with an agency. For these reasons a home health agency must complete the Medicare certification process before it can become fully operational.

5. Prior to 2007 the Medicare survey and certification process occurred relatively quickly after an agency was licensed and in operation. A reasonable planning assumption was that the agency would only operate for two to three months before being certified. On November 5, 2007, the Center for Medicare and Medicaid Services ("CMS") Survey and Certification Group issued a memorandum giving state survey agency directors priorities for completion of their surveys on behalf of Medicare.[1] Exhibit 1 to these comments is a copy of this memorandum. Four "tiers" were established. Initial surveys of new home health agencies were placed in the lowest priority tier, and state survey agencies were told to perform these surveys only when they had completed all work in the higher priority tiers. In other words, the states were told to perform initial surveys of home health agencies and certain other facilities[2] when and if they can get to it. This means a new home health agency that requests a Medicare certification survey from the Medicare State Survey Agency will have to wait for an undetermined amount of time before being surveyed, because it depends on the volume of higher priority surveys before the Agency. CMS's rationale for giving initial surveys of home health agencies a low priority was that there are CMS-approved accrediting organizations ("AOs") that can perform the surveys. New home health agencies were therefore strongly encouraged to achieve certification and accreditation at the same time.

6. To apply for Medicare certification a North Carolina HHA must first be licensed by the state and have CON authorization for its service area. It must have served a minimum of ten skilled care patients and must be serving at least seven patients to request an on-site Medicare certification survey.[3] The agency can choose to undergo a Medicare certification survey by the State Survey Agency, composed of a team from the licensure and certification section of the Department of Health Services and Regulation ("DHSR"), or choose to seek "deemed status" through accreditation by AO that CMS recognizes for this purpose. Such organizations currently include the Joint Commission and the Community Health Accreditation Program ("CHAP"). The Commission for Accreditation of Rehabilitation Facilities ("CARF") plans to begin accrediting home health agencies in July 2010. An agency that pursues certification through the State Survey Agency first files an enrollment application with the Medicare Administrative

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[1] Center for Medicaid and State Operations/Survey and Certification Group, Memorandum S&C-08-03, Initial Surveys for New Medicare Providers, November 5, 2007.

[2] Ambulatory Surgery Centers, Hospices, Hospitals, Critical Access Hospitals, Comprehensive Outpatient Rehabilitation Facilities, Long Term Care Units in Hospitals, Nursing Homes that do not participate in Medicaid, Outpatient Physical Therapy, and Rural Health Clinics

[3] North Carolina Department of Health Service and Regulation.
http://www.dhhs.state.nc.us/dhsr/ahc/flohh.htm

Contractor ("MAC"), in this case Palmetto GBA. Upon receipt the MAC verifies the completeness of the application and, once deemed complete, notifies the State Survey Agency of the need to schedule an unannounced site visit to verify compliance with the Medicare Conditions of Participation ("CoPs").

7. Once approved for enrollment, whether through accreditation and deemed status or through a Medicare certification survey, the effective date for certification will be the date the agency satisfied the CoPs for HHAs, which at the earliest would be the date the agency passed the site survey. Therefore, once an agency successfully completes a survey it is able to serve Medicare and Medicaid patients and be paid for those services when and if certified, but may not send the bills for these services to the Medicare program until certified.

8. An agency that pursues certification through accreditation must satisfy the AO's accreditation standards and satisfies the Medicare CoPs, as determined by the AO. Upon doing so the HHA is "deemed" to have passed the Medicare certification survey and is eligible for enrollment in the Medicare program. As this implies, being accorded accreditation and deemed status does not automatically grant enrollment into the Medicare program. Rather, upon receiving accreditation the agency must prepare and submit a Medicare enrollment application that is processed by a MAC before being enrolled and assigned a Medicare Provider Number ("MPN").

9. Taking the process with the Joint Commission as an example of pursuing certification through accreditation[4], the agency must be licensed before it can apply for accreditation. An agency will require some time to prepare its application. It is possible for the agency to be accredited and afforded deemed status as early as three to four months after filing the accreditation application, but there is no guarantee that it will not be more than four months. Sometime after the survey the AO prepares its accreditation decision report with notice of any deficiencies. If the agency is seeking deemed status, the AO will notify CMS of its accreditation decision and the agency's satisfaction of the Medicare CoPs. Assuming the AO grants accreditation and deemed status, CMS will then proceed to process the agency's Medicare enrollment application, which could take up to an additional three to four months.

10. Using the deemed status option through an AO approach, the shortest time from licensure to accreditation appears to be six to eight months and a more reasonable time estimate appears to be ten to twelve months. The survey report could be issued as soon as six months after licensure, but it could take several months longer. The AO has no control over how long CMS takes to process the Medicare enrollment application after the accreditation report is submitted. CMS may take three to six months to process the

[4] The Joint Commission. 2009. Understanding Joint Commission's Home Health and Hospice Deemed Status Option. September 24. Please see Exhibit 5 for a copy.

application.[5] We are under the impression that the new Bayada agency in Wake County was not certified until about a year after it was licensed.[6]

11. To summarize, there are three time periods after CHHNC is licensed that have different implications for patient volume and financial projections. The time period in parentheses is what Community has assumed for its application.

- Before survey report (10 months) – In this period the agency cannot earn revenue for services to Medicare and Medicaid patients. Many commercial plans are unlikely to contract with the agency. The agency must serve a minimum of ten patients and must be serving seven patients at the time it is surveyed. The agency will have limited operations and staff designed to serve a low volume of patients to satisfy all legal requirements, but to conserve resources. Most of the patients served will be uninsured patients.

- After survey report, before CMS approval and MPN assignment (2 months) – If there are no serious deficiencies, the effective date of certification is the date the agency satisfied the Medicare CoPs, which at the earliest would be the date the agency passed be the site survey. In this period the agency operations and staff will be ramped up to full operations. The agency can earn revenue for services to Medicare and Medicaid patients but will not be able to bill and collect for these services yet. There will be more commercially insured patients.

- After CMS approval of certification and MPN assignment (month 1 of year 2 and after) – In this period the agency will be in full operation and patient volume should increase steadily. The number of commercial patients will increase as contracts are signed with managed care organizations. Cash flow will improve as the agency is able to "back bill" and collect for services delivered in time period 2. The agency will also be able to routinely bill for all services delivered to Medicare and Medicaid patients after the certification date.

12. Community will use the deemed status option and will select the AO that appears able to offer the most timely service. We have included the fees for accreditation in Year 1 expenses. The administrator of CHHNC will be responsible for preparing for accreditation and certification. We have access to the necessary policy and procedure documents through the Camellia agency in Atlanta, and thus should be able to quickly prepare an approvable application. It is completely in Community's financial interest to have a successful accreditation report as quickly as possible in order to be able to ultimately be paid for serving Medicare and Medicaid patients.

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[5] By way of example, simple new enrollments for physicians who are not surveyed and who do not have to be accredited currently take on average 3-4 months, and in some cases take up to 6 months.

[6] According to Mike McKillip, Project Analyst, Certificate of Need Section, DHSR, a Certificate of Need for Bayada Nurses was issued in January 2009. According to Helen Alexander, Team Leader, Certificate of Need Section, DHSR, Bayada Nurses received a site survey and was Medicare-certified in January 2010.

13. In preparing its utilization and financial projections Community has intentionally made conservative assumptions on when a post-survey report would be issued and when we would receive Medicare certification. The application assumes we receive a successful post-survey report ten months after licensure and we can then serve Medicare and Medicaid patients. At this time CHHNC can ramp up to full operations. We assume we receive Medicare certification and MPN twelve months after licensure. This assumption affects collections and cash flow because it determines when CHHNC can begin sending bills to Medicare and Medicaid.

14. Also to be conservative, we have assumed that CHHNC will not attract a substantial number of commercially insured patients until it is Medicare certified. The rationale is that commercial carriers look to certification and accreditation of home health agencies as a seal of approval and will wait to contract with a new agency until it passes these milestones. We will be in conversation with the commercial carriers as soon as we are licensed so contracts can be ready to be signed.

15. **Community believes there is a fatal flaw in each of the competing applications that makes their financial projections and the amount of committed funds unreasonable relative to Criterion 5. For this reason, only CHHNC should be found to conform to Criterion 5.**

16. Each applicant states it will be a new provider and will have to obtain a Medicare provider number.[7] Each says it will be Medicare-certified in three months or less. Based on the projected number of monthly referrals in the first year of operation, each assumes it will be fully operational by the third month or sooner. Each says it will be accredited by one of the accrediting agencies. However, none of the applicants discuss the accreditation or certification process or explicitly budgets funds to pay for accreditation. All applicants, except CHHNC, assume around 80% of patients in Year 1 will be Medicare or Medicaid. Figure 1 summarizes facts from the competing applications.

17. It appears that the competing applicants based their assumptions on the timing of Medicare certification on the CMS policy and procedure prior to that time. As Bayada's recent experience shows, even an experienced HHA owner will require many months to obtain certification, even using the route of accreditation and "deemed" status. The unreasonable assumptions on the timing of Medicare certification lead to unreasonable assumptions on the amount and timing of revenues during the first year of operations. This in turn causes these applicants to commit an inadequate amount of funds to cover cash requirements during the first and second years of operation. The inadequate funding commitment makes the competing applicants unable to demonstrate short-run

[7] The one possible exception to this is 3HC, which has a Medicare-certified Johnston County HHA and could bill through that provider number until the Wake County HHA is certified. (This raises the question of why it would make sense to approve this application as it does not increase the number of current HHAs serving Wake County.) If ISC completes its purchase of an HHA from the County of Durham its position would be the same as 3HC's.

financial feasibility. The combination of factors makes each of them non-conforming with Criterion 5.

Figure 1

	Continuum	United	Assisted Care	ISC[8]	SunCrest	3HC	CHHNC
Year 1 beginning date	4/1/2011	7/1/2011	1/1/2011	1/1/2011	1/1/2011	10/1/2011	3/1/2011
Certification date	4/1/2011	10/1/2011	1/15/2011	12/31/2010	2/28/2011	9/1/2011	12/31/2011
Months from opening to certification	0	3	0	3	2	(1)	10
Yr 1 mo 1 # undup patients	16	16	30	3.75	10	41	5
Yr 1 mo 2 # undup patients	38	28	33	5.77	19	38	5
Yr 1 mo 3 # undup patients	39	36	34	9.8	30	42	3
Yr 1 mo 6 # undup patients	39	36	38	24.83	43	48	3
Yr 2 mo 1 # undup patients	40	44	38	28.02	41	43	28
Yr 2 mo 12 # unduppatients	40	52	41	41.16	53	37	39
Medicare/Medicaid % Gross Revenue Yr 1	88%	95%	77%	81%	88%	80%	42%

18. Figure 2 shows the shortfall in funding for each applicant assuming ten months from opening are required to obtain a successful post-survey report. The number of months of lost Medicare and Medicaid revenue is calculated as ten minus the number of months the applicant assumed would be required for Medicare certification. In all cases the funding committed is inadequate to assure short-term financial feasibility.

19. Community acknowledges that no one can predict with certainty the exact number of months that will be required to complete the certification process for a new HHA, just as in a CON for a new hospital no one can predict with certainty the exact number of months to complete construction. However, in both cases the applicant has the obligation to make a reasonable estimate of the time required and make patient volume, staffing, expense and revenue assumptions that are internally consistent. A CON applicant for a new hospital could not reasonably base the application on a six month construction period and say they will make adjustments if it takes longer. Likewise, in this HHA batched review the other six applicants cannot reasonably make the assumption that Medicare-certification will occur immediately upon opening or within three months and base their other assumptions and projections on that unreasonable assumption.

[8] The actual start date for Innovative Senior Care ("ISC") is October 2010 – it includes three months in "startup" where it is not billing Medicare or Medicaid.

Figure 2

Applicant	Funding Committed	Funding Required per Application	Additional Months for Certification	Revenue Lost	Corrected Funding Required	Funding Shortfall
Continuum	$319,520	$319,520	10	($800,000+)	$1,119,520	($800,000)
United Home Care	$700,000	$558,419	7	($900,000+)	$1,458,419	($758,419)
Assisted Care	$239,766	$239,766	10	($600,000+)	$839,766	($600,000)
ISC	$800,000	$698,407	7	($200,000+)	$898,407	($98,407)
Suncrest	$450,000	$334,043	8	($600,000+)	$934,043	($484,043)
3HC	$250,000	$140,000	10	($600,000+)	$740,000	($490,000)

20. For the other applicants to adopt a reasonable schedule for Medicare certification would require them to revise some or all their assumptions for referrals, staffing, expenses, revenues and funds committed to show short-term financial feasibility and to show their assumptions were reasonable and internally consistent as required by Criterion 5. However, to revise their assumptions would be impermissible amendments to their applications. The applications other than CHHNC are fatally flawed and must be found non-conforming with criterion 5. In the comments on the individual applications we provide specific financial analysis on each applicant.

Unnecessary Duplication of Authority to Serve Wake County

21. The authority DHSR grants when it issues a CON for a Medicare-certified HHA is for the establishment of an agency with its office located in a specified county. State and federal law does not limit the newly established HHA to serving only patients in the county where its office is located. The State of North Carolina has interpreted a CMS policy document[9] as allowing home health workers to serve patients residing within 60 minutes driving time of the HHA office. The policy question is how far away from an office HHA management can exercise adequate supervision to assure quality of care. Therefore it is perfectly legal for HHAs with offices in adjacent counties to seek referrals in Wake County and to serve residents of Wake County. It thus comes as no surprise that 17% of Wake County residents receiving home health services received them from HHAs without offices in Wake County.

22. While a HHA with a CON for an office in an adjacent county may not open a HHA office in Wake County, it can establish one or more of what CMS calls a "drop site" and what DHSR calls a "way station" in Wake County by writing a letter stating the

[9] HCFA Program Issuance Transmittal Notice, Region IV, "Process for HCFA Regional Office Approval of an HHA's Application to Participate as a Branch, Parent or Subunit, March 24, 1997.

intention to create one and agreeing to abide by the rules for this limited purpose office. A way station cannot

- Have a sign with the name of the company posted anywhere on the building or door,
- House original clinical charts,
- Be listed as a location on any marketing materials,
- Have a published phone number and the unpublished number cannot be given to the general public, or
- Have regular hours or regular staff (for example an administrative person there to answer the phone from 8 to 5)

A way station does not extend the HHAs service area for Medicare purposes. The 60 minute drive time area still starts at the CON approved site. With electronic medical records, digital telephones other management tools a HHA in an adjacent county that wants to serve Wake County residents can do so. As an example, 3HC states in its application that it currently receives and serves over 400 referrals per year from Wake County.

23. Two of the six applicants competing with CHHNC currently have or will soon have the legal ability to solicit referrals and deliver home health services in all parts of Wake County. They are 3HC and ISC. In regard to expanding the number of organizations trying to meet the unmet need for home health services in Wake County it would be an ineffective action on DHSR's part to approve the applications of either 3HC or Innovative Senior Care for a CON to establish a Medicare-certified HHA in Wake County.

24. According to its web site, 3HC's Johnston County office is located at 723 S. Third St., Suite C, Smithfield, North Carolina 27577-9300. The web site states the office is "Serving Harnett, Wake and Johnston counties and the city of Durham."[10] On the same page 3HC provides a map of its service area, which is reproduced as Figure 3 below. It shows 3HC considers all of Wake County to already be in its service area. Exhibit 8 shows the estimated 60 minute driving tine from the 3HC office in Smithfield, which confirms that including Wake County in the 3HC service area is consistent with State policy.

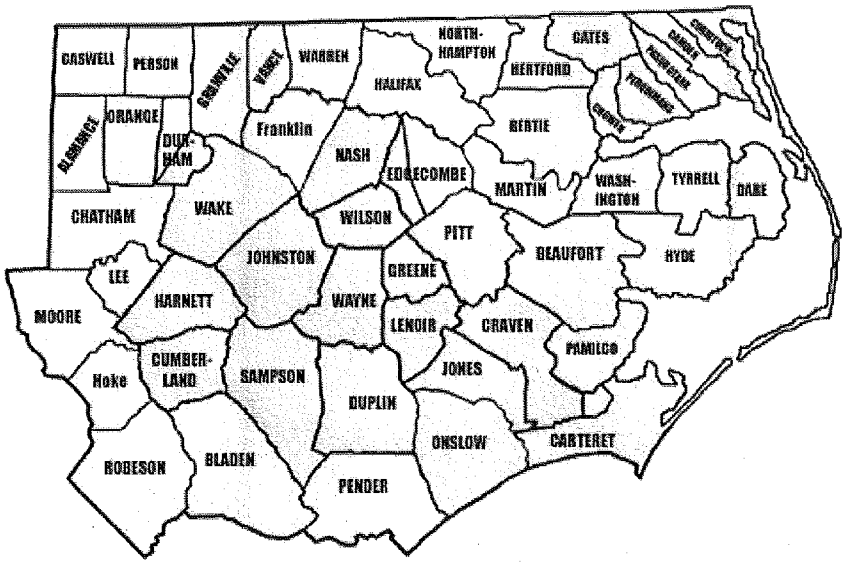
25. According to the 3HC application, its Johnston County HHA served 300 Wake County residents in 2008 and 422 in 2009.[11] 3HC has had a home health office (non-Medicare certified) and a way station for its Johnston County HHA (Medicare-certified) at the same location for several years. That office was operated solely as a way station beginning December 15, 2008 and was moved to Donmoor Court in Garner on March 1, 2010. The current location of the way station is the same site where 3HC

[10] http://www.3hc.org/locations.html. viewed May 25, 2010.
[11] 3HC CON Application, p. 52.

proposed to establish the Medicare certified HHA.[12] The number of Wake County residents 3HC projects it will serve from both its Johnston and Wake offices if its CON is approved is essentially the number it is serving **now** from its Johnston HHA.

Figure 3

3HC Self-Defined Service Area



26. Based on its own representations 3HC has a well-established home health business in Wake County and can expand this business **without** obtaining a separate CON for a Wake County office. 3HC projects it will serve about the same number of Wake County residents with or without the Wake County CON. Therefore granting 3HC the CON for Wake County would do nothing to meet the unmet need in Wake County identified in the 2010 SMFP.

27. Like Johnston County, Durham County is adjacent to Wake County and a HHA based in Durham County can serve residents throughout Wake County. The County of Durham owns a Medicare-certified HHA that it is seeking to sell through a public bidding process. The office for this HHA is currently located at 414 E. Main Street, Durham, NC 27701. The map in Exhibit 8 shows the 60-minute driving time contour from this office, which includes all of Wake County.

28. Exhibit 2 to these comments is an email dated April 30, 2010 from Ronald H. Clitherow to representatives of the ten organizations that submitted letters of intent. Many of those organizations are also applicants in the current CON review. The email

[12] 3HC CON Application, p. 12.

states that "It remains the intent and desire of the Seller (Durham County) for this (the sale) to be completed no later than June 30, 2010."[13]

29. The table that is part of the email shows that the high bidder is Brookdale Senior Living, the parent corporation of Innovative Senior Care. The next highest bidder is UHS-Pruitt, the parent of United Home Care ("United"). Assuming Durham County keeps to its intended schedule one of these two organizations will own Durham Home Health Agency before DHSR awards the CON for Wake County. It would be an unnecessary duplication of services for the same organization to hold CONs for HHAs in both Durham and Wake County since a HHA based in Durham can serve all of Wake County consistent with State policy. It would also reduce consumer choice and competition by blocking the entry of an additional provider like CHHNC to Wake County.

HOME HEALTH PSYCHIATRIC CARE

30. In attempting to differentiate their CON applications, two of the applicants in this batch have emphasized that they intend to provide "psychiatric home health services" and to employ the specialized nursing staff Medicare requires if a HHA is allowed to bill for such services. Community did not state that it would provide these specialized psychiatric home health services for several reasons. For these same reasons we think DHSR should not approve either of the two applications. They are:

- The number of patients who need and qualify for Medicare-funded home health psychiatric care is very small and the number needing these services has not been demonstrated by any applicant.

- There are currently two (soon to be three) HHAs with qualified psychiatric nursing staff providing home health psychiatric care in Wake County. No applicant has shown that there is need for this service not being met by current providers. A fourth HHA trying to provide this service in Wake County would be an unnecessary duplication of services.

- The requirement of a registered nurse with specialized psychiatric training makes it impractical for a start-up HHA with only two or three RNs to provide this service throughout the county, seven days a week, 24 hours a day.

31. The Medicare intermediary for North Carolina has issued a Local Coverage Determination for home health psychiatric care that is attached as Exhibit 3. "Home Health – Psychiatric Care" as defined by Medicare does not mean any home health service delivered to a person with a psychiatric diagnosis. Medicare defines Home Health – Psychiatric Care as that requiring

[13] Email from Ronald H. Clitherow to thillard et al. April 30, 2010, 12:32 pm. See Exhibit 2 for a copy of the email.

> *"The evaluation, psychotherapy and teaching activities needed by patients suffering from a diagnosed psychiatric disorder that requires active treatment by a psychiatrically trained nurse may be covered as skilled nursing care. Patients may also require medical social services, occupational therapy, home health aide visits or other home health services related to the treatment of their psychiatric diagnosis.*
>
> *"The services of a skilled psychiatric nurse must be required to provide the necessary care, i.e., observation/assessment, teaching/training activities, management and evaluation of a patient care plan, or direct patient care of a diagnosed psychiatric condition which may include behavioral/cognitive interventions. Services must be reasonable and necessary for treating the patient's psychiatric diagnosis and/or symptoms."*[14]

Community and most HHAs will provide medical-surgical skilled nursing and a range of therapy services to a patient with a psychiatric diagnosis. This includes medication management services. Community will not decline a referral for the home health services it provides because the person has a psychiatric diagnosis.

Figure 4

Table 5: Medicare Home Health Utilization by Principal Diagnosis, 2006

Principal ICD-9-CM Diagnosis[1]	Principal ICD-9-CM Codes	Patients (1,000's)	Percent
Infectious and Parasitic Diseases	001-139	17	0.6
Neoplasms	140-239	93	3.1
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	19	0.6
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders	240-279	326	10.8
Diabetes Mellitus	250	295	9.7
Diseases of the Blood and Blood Forming Organs	280-289	55	1.8
Mental Disorders	290-319	52	1.7
Diseases of the Nervous System and Sense Organs	320-389	110	3.6
Diseases of the Circulatory System	390-459	646	21.4
Essential Hypertension	401	138	4.6
Heart Disease	402, 410-411, 413-414, 427-428	325	10.7
Diseases of the Respiratory System	460-519	217	7.2
Pneumonia, Organism Unspecified	486	54	1.8
Diseases of the Digestive System	520-579	62	2.1
Diseases of the Genitourinary System	580-629	69	2.3
Diseases of the Skin and Subcutaneous Tissue	680-709	187	6.2
Diseases of the Musculoskeletal System and Connective Tissue	710-739	317	10.5
Osteoarthritis and Allied Disorders	715	49	1.6
Symptoms, Signs, and Ill-Defined Conditions	780-799	264	8.7
Injury and Poisoning	800-999	186	6.1
Supplementary Classification	V01-V82	1,258	41.6
Total, All Diagnoses[2]	—	**3,026**	**100.0**
Total Leading Diagnoses[3]	—	**1,549**	**51.2**

[1]ICD-9-CM is International Classification of Diseases, 9th Revision, Clinical Modification (Volume 1). Only the first listed or principal diagnosis has been used.
[2]Includes invalid codes not listed separately.
[3]Specific leading diagnostic categories were selected for presentation because of frequency of occurrences or because of special interest.
Source: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information. *Health Care Financing Review: Medicare and Medicaid Statistical Supplement*, 2007.

[14] Palmetto Government Benefits Administrators. 2010. LCD for Home Health - Psychiatric Care (L265). Rev. May 13, 2010.

32. As shown on Figure 4 above, only 1.7 percent of home health patients have a primary psychiatric diagnosis.[15]

Further, not everyone with a psychiatric diagnosis is eligible for this service. The patient must be homebound because of the psychiatric condition and thus unable to receive care in a clinic or outpatient setting. To quote the Medicare Local Coverage Decision applicable to North Carolina:

> *1. The patient must be confined to the home. "The condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving the home would require a considerable and taxing effort." A patient with a psychiatric disorder is considered to be homebound "...if his/her illness is manifested in part by a refusal to leave the home, or is of such a nature that it would not be considered safe for him/her to leave home unattended even if he/she has no physical limitations." The following conditions support the homebound determination:*
>
> > *a. Agoraphobia, paranoia or panic disorder*
> >
> > *b. Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairment of thoughts/cognition grossly affect the patient's judgment and decision making, and therefore the patient's safety*
> >
> > *c. Acute depression with severe vegetative symptoms*
> >
> > *d. Psychiatric problems associated with medical problems that render the patient homebound*
>
> *"If a patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for relatively short duration, or are attributable to the need to receive medical treatment."*[16]

In presenting their justification for why more of this service was needed in Wake County neither United nor AssistedCare took account of this coverage limitation in projecting the need for psychiatric home health. Their calculations grossly and unreasonably overstate the number of patients who could receive home health psychiatric care.

33. Not any registered nurse can provide these services. Psychiatrically trained nurses able to provide psychiatric evaluation and therapy in the home are required by Medicare to have special training and/or experience beyond the standard curriculum

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[15] The National Association for Home Care & Hospice. 2008. Basic Statistics About Home Care, Updated.
[16] Palmetto GBA, op. cit.

required for an RN. The Medicare intermediary for North Carolina considers the special training and/or experience requirements to be met if the registered nurse (RN) meets one of the following criteria:

> *a. An RN with a Master's degree with a specialty in psychiatric or mental health nursing and licensed in the state where practicing would qualify. The RN must have nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.*
>
> *b. An RN with a Bachelor's degree in nursing and licensed in the state where practicing would qualify. The RN must have one year of recent nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.*
>
> *c. An RN with a Diploma or Associate degree in nursing and licensed in the state where practicing would qualify. The RN must have two years of recent nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.*
>
> *d. An RN who has worked as a psychiatric Home Health (HH) Nurse within the last calendar year prior to the effective date of this policy (1999) will be grandfathered in.*
>
> *3. On an individual basis, other combinations of education and experience may be considered.*
>
> *4. It is highly recommended that psychiatric RNs also have medical/surgical nursing experience because many psychiatric patients meet homebound criteria due to a physical illness.*[17]

Before a HHA can bill for these services each nurse must be individually reviewed and approved by the Medicare intermediary. The HHA must submit the résumé of any nurse who will be providing psychiatric services to the intermediary. The intermediary will review the résumé and notify the HHA whether the nurse meets the requirements. The notice must be in the file before the nurse provides psychiatric services.

34. It is impractical for a start-up HHA to employ the staff necessary to offer home health psychiatric care in addition to the full range of non-psychiatric home health services. During the initial years of operation all the applicants propose to employ two or

[17] Palmetto GBA, *op. cit.*

three RNs, including the manager. To provide home health psychiatric care 24 hours a day, 7 days a week, all RNS would have to be dually trained and experienced in psychiatric and medical surgical nursing. Unless the HHA is offering exclusively home health psychiatric care it would need to have a much larger staff to provide this service. Neither United nor AssistedCare explained in its application how it would actually provide home health psychiatric care with the number of RNs it specified and budgeted.

35. Criterion 7 (N.C. Gen. Stat. § 131E-183(a)(7) provides that "[t]he 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." By failing to adequately explain how they would provide the necessary staff for the home health psychiatric care they proposed in their applications, the applications of UHS and AssistedCare have failed to conform with Criterion 7.

36. Neither UHS nor AssistedCare mention in their applications that home health psychiatric care is currently available in Wake County. Medi Home Health has a certified psychiatric nurse and offers home health psychiatric care in Wake County.[18] Amedysis has certified RNs and offers psychiatric services to Wake County. [19] Heartland is starting a home health psychiatric care program and will have a certified RN on staff as of June 17th.[20] Given the small number of home health patients in Wake County who would need home health psychiatric care and the specialized staff necessary to provide it, not every HHA in Wake County should provide it. There has been no showing by any applicant that persons qualifying for home health psychiatric care whose physicians have requested it are not being adequately served. It would be an unnecessary duplication of services for a third HHA to provide home health psychiatric care in Wake County, assuming a start-up HHA could actually do so.

37. To summarize the comments on home health psychiatric care, CHHNC will accept referrals to provide home health services to persons with a psychiatric diagnosis, but will not employ a specialized psychiatric nurse to provide home health psychiatric care during the initial years projected in the application. No additional CON would be required should Community see the need to add this service in the future. This decision is based on the fact that a very small percentage of home health patients need this service and there are already three HHAs providing home health psychiatric care in Wake County. Further, it is impractical for a start-up HHA to devote one of only two or three RN positions to a psychiatric-experienced nurse. Neither UHS nor AssistedCare have provided evidence of unmet need for home health psychiatric care in Wake County or acknowledged that several HHAs already provide it. Neither has explained how it will carry the specialized psychiatric RN within the limited staffing shown in its application and also carry the experienced medical-surgical RNs required to deliver the other services each application promises. As a result, both applications fail to conform with Criterion 7.

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[18] Personal communication, Darcy Lewis with Anne O'Malley, Medi Home Health clinical staff, May 20, 2010.
[19] Personal communication, Anne Rivenbark and Angela, Clinical Coordinator, Amedisys, May 25, 2010.
[20] Personal communication, Anne Rivenbark and Chris Popilek, Heartland. May 25, 2010.

COMMENTS ON EACH COMPETING APPLICATION

Continuum II

38. Continuum does not state in its application that it will seek accreditation by any accrediting organization recognized by CMS. (Section IV item 2). They also do not include any funds to cover the expenses of accreditation. Accreditation is of sufficient significance to the development of a HHA that should they now state that they intend to seek accreditation that it would be a material amendment to their application. The lack of accreditation raises questions about their commitment to providing quality care. As discussed above, with CMS's current survey priorities the lack of accreditation makes it questionable if they would ever be Medicare-certified. It will certainly take longer and provides them with no reasonable basis for projecting revenues or cash flow.

39. Continuum has assumed it will need $319,520 in cash to fund operating losses and working capital. It has limited its funding commitment to this exact amount. However, its financial projections assume Medicare certification on opening day, which is clearly impossible and unreasonable. Even with accreditation, a reasonable assumption is that it will take a new HHA ten months from opening to secure Medicare certification. Based on its financial projections, Continuum would have about $800,000 less revenue in Year 1 if it achieves Medicare certification in Month 10. Without accreditation, certification will most likely take many more than ten months which would further increase the funding requirement. Thus its funding commitment is grossly inadequate and its proposal is not financially feasible in the short-run. Continuum has failed to show availability and commitment of necessary funds for its project and, thus, is not conforming with Criterion 5 (N.C. Gen. Stat. § 131E-183(a)(5)). Continuum has further failed to show that its project is financially feasible in the short-run based on reasonable assumptions, again making its application not conforming with Criterion 5.

40. There are also several problems with the financial data in the Continuum application which raise questions about whether it conforms with Criterion #5. It does not appear that CON application preparation costs are included in the financial information in Section VIII: Capital Costs and Financing or in Section IX: Start-Up and Initial Operating Expenses/Financing. What are estimated costs, and where are they included in cash requirements?

41. In Section IX the Cash Flow statement indicates a Year 2 cash increase of $107,829, while the pro forma Balance Sheet indicates an increase of $47,793 ($62,572 Year 1 to $110,365 Year 2). There is no explanation provided regarding this discrepancy.

42. Information is not provided in the Summary of Significant Forecast Assumptions detailing calculations of gross and net revenue by payor, other than for Medicare and Medicaid. No contractual allowances or deductions from gross revenue are shown on Form B: Statement of Revenues and Expenses for commercial insurance, private pay, or VA. It is not reasonable to assume reimbursement at full billed charges. Therefore, net revenues are overstated.

43. On the issue of financial access, Continuum has worded its application so as to make no commitment. On page 78 is this question and answer:

> *(a) Will all persons have access to the proposed services regardless of their ability to pay?*
>
> *Patients will be accepted for care without discrimination on the basis of race, color, creed, sex, age, sexual orientation, handicap (mental or physical), communicable disease, or place of national origin. All efforts will be made to accept every potential patient that is appropriate for home care, regardless of payment source.*

What does "all efforts" mean? Continuum later states that it has no legal obligation to provide charity care, so doing so or not is completely within its discretion and the only "effort" required to provide services to a patient without insurance or personal financial resources is for Continuum to agree to do so.

44. Finally, Hillco, the parent organization of Continuum also owns nursing home, durable medical equipment and pharmacy subsidiaries.[21] Because the HHA nurses and therapists are in the position of recommending vendors to the patient and attending physician, approving the Continuum application creates a situation where recommendations may be based on the financial interests of the parent corporation and not the best interests of the patient. Where there are qualified applicants like CHHNC that do not have these conflicts of interest, this is a factor that DHSR should consider in a comparative review.

United Home Care

45. United Home Care ("United") is one of the applicants that has proposed to offer home health psychiatric care. For the reasons discussed above Community thinks this is clearly not a positive factor in the United application, but rather is a negative factor because of the unnecessary duplication of home health psychiatric care services already offered in Wake County. Further, for the reasons discussed above, United has failed to demonstrate that it has adequate staff with appropriate qualifications to provide home health psychiatric care. As a result, its application is non-conforming with Criterion 7 (N.C. Gen. Stat. § 131E-183(a)(7)).

46. An additional concern specific to this application is the method United presents to attempt to show need for psychiatric home health services. It is sufficiently flawed as to be unreliable and unreasonable. The method is presented in Exhibit 57 to the United application, which is reproduced as Exhibit 4 to these comments. Briefly stated, the problem are as follows:

- The number of Wake County home health patients in need of home health psychiatric care is calculated as the total number of Wake County home health patients times 3 percent. The three percent is the percentage of

[21] Continuum CON Application. 2010. Volume 2, Tab L. Hillco, Ltd. and Subsidiaries, Consolidated Financial Statements, September 30 ,2009 and 2008, p. 323, note 1.

Wake County residents over 65 who were hospitalized with a mental health diagnosis.

  - United used the national hospital discharge rate to represent Wake County which is not reasonable given that data are available from which rates specific to Wake County can be computed.
  - There is no logical relationship between the percentage of hospital discharges with a mental health diagnosis and the percentage of home health patients with a mental health diagnosis.
  - Data from the National Association of Home Care cited above shows the percentage of home health patients with a mental health diagnosis is 1.7%

- United assumes that all home health patients with a mental health diagnosis are eligible for home health psychiatric care. As discussed above based on the Palmetto Local Coverage Determination (Exhibit 3), only persons with specific mental health diagnoses who are homebound and who need psychiatric nurse evaluation counseling as part of their treatment plan are eligible for home health psychiatric care. United has made no attempt to estimate what percent of home health patients with mental health diagnoses would be eligible.
- United assumes all need for home health psychiatric care is unmet need. The application ignores the fact that multiple Wake County HHAs currently have certified psychiatric nurses and offer home health psychiatric care. With the small number of people who are eligible for this service, the current supply likely matches the need. United in no way proves unmet need. Therefore, United's application fails to show conformity with Criterion 3 (need) and Criterion 6 (unnecessary duplication).

47. United also fails to explain how it will carry a specialized psychiatric nurse as part of the total of 2.3 RNs budgeted for Year 1 and 3.6 RNs budgeted for Year 2 and still have sufficient medical-surgical RNs to meet the needs of the other home health patients it plans to serve. United's pro forma Form B, Projected Statements of Revenue and Expenses, states that this RN staff includes psychiatric.[22]

48. In Section IV – Utilization, United makes unreasonable assumptions on visits per unduplicated patients. Figure 5 ranks the applicants from the highest number of visits per unduplicated patient to the lowest number of visits per unduplicated patient.

[22] United CON Application. 2010. Section VII, Staffing, Tables VII.1 and VII.2, pp. 192-193; United CON Application. 2010. Form B, Projected Statements of Revenue and Expenses, Nursing Services, p. 221.

Figure 5

	Unduplicated Patients (Y2)[23]	Visits (Y2)[24]	# Visits per Pt. In Year 2
United Home Care	588	13710	23.3
Continuum II	480	8839	18.4
3HC	497	8782	17.7
Community	410	7134	17.4
AssistedCare	474	7551	15.9
SunCrest	484	7611	15.7
Innovative	444	6705	15.1

According to data from Palmetto GBA-MSAD's *Quarterly Home Health Coalition Report Description* of June 2007 from January 2006 through March 2006, Medicare-certified home health agencies in MSAs in North Carolina provided an average of 1.2 episodes of care per Medicare beneficiary, and 14.65 visits per 60-day episode of care. Therefore, each Medicare beneficiary averaged about 17.58 visits during this period *(14.65 visits per episode of care x 1.2 episodes per year = 17.58 visits*). United projects the highest number of visits per unduplicated patient. However it fails to show that its projections are reliable. The applicant did not provide sufficient information to demonstrate it is reasonable to project it will provide 30% more visits per patient than the statewide average.

49. UHC projects the same volume in Y2 and Y3 (588 patients).[25] It claims this is "conservative based on the overwhelming need described in [section III]."[26] However, the need shown in Section III is for 1,056 and 1,377 home health patients in project years 2 and 3,[27] and the applicant "believes these estimates are extremely conservative".[28] If the need is growing, why does the applicant project to cap utilization at year 2 volumes? Home health agencies staff to volume and there are no physical capacity constraints. The projection for Year 3 is not reasonable.

50. Community has questions about some of United's financial assumptions. The financial assumptions refer to a working capital loan: "UHCW will not repay its working capital loan within the first two years." The cash funding from United Service does not indicate that the cash advanced is a loan, nor do Sections VIII (Capital Costs and Financing) and IX (Start-Up and Initial Operating Expenses). What are the terms of the loan? There is no interest included in the pro forma income statement; what interest is applicable during the first two years of the project? The failure of United to provide an explanation for the terms of its "working capital loan" impacts its conformity with Criterion 5.

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[23] Section IV, Utilization, Table IV.1
[24] Section IV, Utilization, Table IV.2
[25] Section IV, Utilization, page 134
[26] Section IV, Utilization, page 134
[27] Section III, Need/Demand, page 117
[28] Section III, Need/Demand, page 116

51. Accreditation is an important step in Medicare certification which is critical to the financial feasibility of the proposed HHA. Section VI, Accessibility, item 2 indicates United will become accredited by the Joint Commission.[29] However, accreditation expenses are not explicitly shown in the expense budget. How much expense is budgeted in the financial pro forma, and where is it included? Again, this impacts conformity with Criterion 5.

52. United has made unreasonable assumptions regarding how long it will take after opening to obtain Medicare certification. The assumption in the application is that certification will be obtained after three months of operation. As discussed above, ten months is a reasonable assumption and three is not. Based on certification after three months United has projected cash requirements of $558,419 and has committed $700,000 in its funding letter. Based on the financial pro forma, operating an additional seven months without certification will require additional funding of about $900,000. United's revenue projections are not reasonable. Therefore the funding United has committed is inadequate to meet the cash requirements of the proposed HHA during the first years of operation. United's application is not financially feasible in the short run. United has failed to show availability and commitment of necessary funds for its project and, thus, is not conforming with Criterion 5. United has further failed to show that its project is financially feasible in the short-run based on reasonable assumptions, again making its application not conforming with Criterion 5.

53. Finally, United Services, the parent organization of United Home Care, also owns nursing homes, durable medical equipment and pharmacy subsidiaries.[30] Because the HHA nurses and therapists are in the position of recommending vendors to the patient and attending physician, approving the United application creates a situation where recommendations may be based on the financial interests of the parent corporation and not the best interests of the patient. Where there are qualified applicants like CHHNC that do not have these conflicts of interest, this is a factor that DHSR should consider in a comparative review.

AssistedCare Home Health

54. AssistedCare is the other applicant that proposes to provide home health psychiatric care. For the reasons discussed above Community thinks this is clearly not a positive factor in the AssistedCare application, but rather is a negative factor because of the unnecessary duplication of home health psychiatric care services already offered in Wake County.

55. An additional concern specific to this application is the method AssistedCare presents to attempt to show need. It is sufficiently flawed as to be unreliable and unreasonable. AssistedCare provides a discussion of planned cuts in residential services for mentally ill and mentally disabled patients based on local mental health plans. An excerpt from the application quoting a local plan reads as follows:

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[29] United CON Application. 2010. Section VI, Accessibility, p. 165.
[30] United CON Application. 2010. Exhibit 3, UHS-Pruitt Services, pp. 334-362.

> *As shown in Table 1 (see Exhibit 19), a large number of residents (approximately 14,000 adults statewide. This number is based on the table note which indicates that two-thirds of the total 32,106 will need case management or another replacement service.) who receive community support services (which will be eliminated in June 2010) will require case management or some other similar replacement service. Several of the gaps identified by the Wake County LME are services that can be provided by a behavioral health home care and/or home health services (depending on the specific needs of the patient and payor requirements), including:*
>
> ✓ *Need for family psychoeducation;*
>
> ✓ *Need for education and employment supports;*
>
> ✓ *Need for improved transition planning;*
>
> ✓ *Need for more respite options;*
>
> ✓ *Need for qualified and licensed professions to address clinical needs and who also accept Medicaid reimbursement;*
>
> ✓ *Need for support for senior Developmentally Disabled residents who are retiring and want to remain in their homes;*
>
> ✓ *Need for supervision and medical care for aging Developmental Disability residents who tend to develop early onset dementia and Alzheimer's;*
>
> ✓ *Need for crisis response; and,*
>
> ✓ *Need for facility safety, security, hygiene assessment/ education.*[31]

The problem in basing need for a Medicare certified HHA on this reduction in state services is that AssistedCare makes no showing that Medicare or Medicaid would pay a HHA to provide these services or that the patients have diagnoses that would make them eligible for Medicare home health psychiatric care. No estimate is provided of the number of eligible patients in Wake County.

56. Another concern with the need assessment for home health psychiatric care is that AssistedCare does not acknowledge the existence of multiple existing providers of home health psychiatric care. To the extent there is a growing need for home health psychiatric care services among Medicare and Medicaid patients eligible to receive these services AssistedCare should analyze the ability of the existing Wake County HHAs to meet this need before proposing to add an additional provider. This impacts conformity with Criterion 6 (unnecessary duplication of existing services).

57. Much of AssistedCare's behavioral health services appear to be financed not through home health agency payments, but through direct contracts with the State and with local behavioral health programs. No reason is given why AssistedCare cannot provide its behavioral health services in Wake County without receiving a CON. AssistedCare provides no data on what volume of behavioral health services it currently

[31] AssistedCare. 2010. Home Health CON Application, p. 55.

provides through its Medicare certified HHA and what volume it provides through other funding mechanisms. How necessary is it for AssistedCare to have a CON to fund the services it proposes to provide?

58. Community has several questions and concerns on the financial projections in the AssistedCare application. It does not appear that CON application preparation costs are included in the financial information in Section VIII: Capital Costs and Financing or in Section IX: Start-Up and Initial Operating Expenses/Financing. What are estimated CON costs, and where are they included in cash requirements?

59. In Section VIII: Capital Costs and Financing indicates there is no management contract, yet the financial pro forma includes management services costs.

60. AssistedCare's annual salary for an RN is significantly below that of all other applicants. What is the source for these salary projections? Is this reasonable for the Wake County area or is it based on salaries in AssistedCare's current location?

Year 1: $55K for AssistedCare vs. $62K-$67K for other applicants
Year 2: $57K for AssistedCare vs. $64K-$69K for other applicants

Either the salary costs have to be amended or it is not reasonable to assume AssistedCare will be able to employ nurses at the salaries shown.

61. In Section VI, Accessibility, item 2 indicates AssistedCare will be accredited by the Joint Commission. Where are the accreditation expenses budgeted in the financial pro forma, and how much is the expense? The lack of expense or explanation impacts conformity with Criterion 5.

62. The financial assumptions indicate depreciation is calculated using a life of 10 years for all assets. Nearly 90% of capital spending is for computer equipment. A 10-year life is too long for computer equipment. This assumption is unreasonable and has the effect of understating depreciation expense. Again, this impacts conformity with Criterion 5.

63. The supplies charges and payment are much higher for Medicaid than for other payors. AssistedCare assumes an average per visit supplies charge for Medicaid of $68, while the average per visit supplies charge for all other payors is $16. Why is this charge for Medicaid over four times that for other payors? Again, this presents another issue with conformity on Criterion 5.

64. AssistedCare has assumed it will need $239,765 in cash to fund operating losses and working capital. It has limited its funding commitment to this exact amount. However, its financial projections assume Medicare certification on opening day, which is clearly impossible and unreasonable. Even with accreditation a reasonable assumption it that it will take a new HHA ten months from opening to secure Medicare certification. Based on its financial projections, AssistedCare would have about $600,000 less revenue in Year 1 if it achieves Medicare certification in Month 10. The funding requirements will further increase if AssistedCare must pay higher salaries for nurses than it has

budgeted. Both its revenue and expense assumptions appear unreasonable. Thus its funding commitment is grossly inadequate and its proposal is not financially feasible in the short-run. AssistedCare has failed to show availability and commitment of necessary funds for its project and, thus, is not conforming with Criterion 5. AssistedCare has further failed to show that its project is financially feasible in the short-run based on reasonable assumptions, again making its application not conforming with Criterion 5.

ARC Therapy Services, LLC d/b/a Innovative Senior Care

65. ARC Therapy Services, LLC d/b/a Innovative Senior Care ("ISC") is a wholly owned subsidiary of Brookdale Senior Living, Inc. Brookdale Senior Living has 548 senior living communities in 35 states, including North Carolina.[32] ISC "currently provides therapy services in Wake County at four Brookdale Communities…ISC Home Health is seeking to compliment the existing therapy services by adding home health care and serving all the population in need in Wake County."[33]

66. It appears that ISC historically offers home health services only to members of local Brookdale Senior Living communities. As evidenced by the attached Innovative Senior Care page and ISC Jobs pages of the company's website (Exhibits 6 and 7), the home health services are provided to community residents. The web page states "Innovative Senior Care (ISC) is committed to making the lives of our senior residents more meaningful and enriched." There is no mention of services provided to non-residents in need of home health services. The ISC Careers webpage describes ISC as a company that uses "nursing, therapy and wellness techniques to provide lifestyle enhancements for residents of senior living communities. Our services enable residents to live better…"[34] Again, ISC is advertising itself as a company that provides home health services only to residents of Brookdale communities. The results of a Job Search performed on the website returned an Assistant Director of Home Health Professional Services in Richmond, Virginia. The description indicates that the opening is for an "onsite home health agency serving upscale retirement communities" and also states that there is "minimal" travelling involved in the job.[35]

67. In Wake County, ISC is currently an outpatient therapy company operating within the Brookdale Communities in Wake and adjacent counties. ISC employs therapists to provide services to the residents of Brookdale. When appropriate, ISC provides services under Medicare Part B; however, if the resident requires skilled nursing or can be appropriately billed through Medicare Part A the patient is referred to a home health agency for services. In Wake County ISC has an agreement with a local home health agency to provide these services. In turn the agency has a contract with ISC to provide the therapist to perform the services. The home health agency bills Medicare Part A and receives the episodic PPS payment. ISC bills the home health agency a per visit

[32] Innovative Senior Care. 2010. Certificate of Need Application April 15, p. 6.
[33] *Ibid.*, 8.
[34] For this and previous quote, please see the ISC Website pages in Exhibit 6.
[35] Please see "JobSeeker—Richmond, Virgnia" Exhibit 7.

charge for the therapy visits performed. The principal effect of giving ISC the CON would be to allow them to bill Medicare directly once certified and presumably keep a larger share of the revenue generated by its captive audience.

68. Despite the assertion in the application that ISC intends to serve all patients in Wake County in need of home health services, the first year utilization projections presented in the CON application indicate that it will draw its patients solely from Brookdale Senior Living facilities. The applicant's Year 1 projections are "primarily based upon the client's 2009 referrals to home health" during which time "ISC's Wake-based facilities referred 201 patients (ISC residents) to home health care." ISC states that while patient choice of home health providers "will, of course, be honored...it is expected that the majority of ISC residents needing home care will choose ISC's proposed project." The applicant's projected year one population is 230 unduplicated patients. This was calculated by multiplying the number of Brookdale patients that were referred out for home health services in 2009 by a compound annual growth rate for Wake County. 201 (2009 Referrals) x 107% (2004-2008 compound annual growth rate for Wake) = 230.[36] Clearly, ISC is projecting its first year patient base to come solely from referrals made to its home health agency by its parent company Brookdale. Moreover, the applicant does not reach any patients who have unmet needs, as the 230 patients would have been referred to another HHA by Brookdale if ISC were not granted CON approval.

69. Furthermore, ISC has four more Innovative Home Health providers in counties contiguous to Wake: one in Durham, and three in Chapel Hill. It reports that these four facilities accounted for an additional 140 residents who were referred for home health services, creating a total of 341 residents of Brookdale being referred to home health services.[37] Following ISC's methodology, they can rely on a 7% increase on these internal referrals for each of the first three years they are operating. This would mean that the Brookdale facilities in Wake County and contiguous counties could account for 364 patients in the first year, 390 in the second year, and 417 in the third year. When ISC's ability to draw upon its patient base in contiguous county is taken into account, it is very clear that very few Wake County patients with unmet needs can expect to be served if ISC is given the CON.

70. Understandably ISC's first priority is meeting the needs of the upper income residents of Brookdale retirement communities. Providing home health services to the community at large is a secondary service line. Even if we assume the Wake HHA will serve only Wake County residents, ISC does not fully address the unmet need published by the state. In year 2, ISC projects it will serve 444 patients, meeting the need presented by the state. However, it can be assumed that ISC will continue to draw upon patients from Brookdale that it would have referred to other HHAs (the 230 discussed above). When multiplied by the 7% growth factor ISC uses above, it is clear that 246 of the projected patients will come from Brookdale, and ISC will only be serving 198 patients

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[36] *Ibid.*, 33.
[37] Innovative Senior Care. 2010. Certificate of Need Application April 15, p. 36.

that would have had an unmet need. In Year 3 they will only serve 212 patients that would have otherwise had an unmet need for home health services.[38]

71. As discussed above, it now appears that granting ISC a CON for Wake County would be an unnecessary duplication of services because Brookdale is about to acquire a Medicare-certified HHA in Durham County. A Durham County HHA would be able to serve all residents of Wake County as well. Exhibit 2 shows that Brookdale is the high bidder and that the sale of the HHA is expected to be completed by June 30, 2010. If that occurs it should end any serious consideration of ISC as an applicant for the Wake County CON.

72. Community has several questions and concerns about the financial assumptions in the ISC application. The number of questions raised by ISC's financial data causes us to question whether its financial projections are reasonable and reliable.

73. Section VII: Staffing states "We offer a Retention Bonus Plan to select key therapy and nursing associates within ISC. This Retention Plan pays the ISC associate a significant cash bonus for each year he/she remains on board with ISC. Bonuses differ depending on the associate's position and on the associate's tenure with the company, but range from $2,000 - $4,500 annually."[39] The application indicates that these bonuses apply to therapy and nursing staff. ISC states that therapists are already in place as full time employees. However, there appears to be no expenses budgeted for bonus payments in the financial pro forma. ISC should either state the amount included in Year 1 and Year 2 for bonus payments, and where these costs included, or acknowledge that labor expenses are understated.

74. ISC appears to have understated the staffing and staffing expense required by its volume projections. Section VII: Staffing assumes clinical staffing is calculated using 260 days per year. This significantly understates FTEs and corresponding salaries and benefits cost, as this does not allow for vacations, holidays, sick leave, etc. For example, the 2,594 skilled nursing visits for Year 2 would require 1.8 FTEs working 240 days per year, rather than the 1.66 in the staffing table.

6 visits per day x 260 days = 1,560 visits per year. 2,594 / 1,560 = 1.66.
6 visits per day x 240 days = 1,440 visits per year. 2,594 / 1,440 = 1.8.

75. Section IX: Start-Up and Initial Operating Expenses/Financing indicates that it includes costs for patients for a three-month period. ISC included 3 months of non-revenue patient care in "start-up". Under North Carolina rules, the first day of the financials is supposed to be when the office opens. ISC has more cost in startup and less cost in initial operating expenses than it should have. The effect on the financials is that the pro forma looks better than the actual first two years after opening – instead of

[38] Projected patients in years 2 and 3 from Innovative Senior Care Certificate of Need Application April 15, 2010. pg. 33. Year 3 unduplicated patients=Total projected patients(475) minus patients drawn from Brookdale that would have been otherwise referred to existing HHAs (246*1.07=263)
[39] Innovative Senior Care. 2010. Certificate of Need Application April 15, p. 83.

showing months 1 – 24 in the pro forma, ISC shows months 4 – 28. The month they show as breakeven in the pro forma should be shown 3 months later since the first 3 months of operations are included in startup.

76. Section IX item 3 states that Home Office Cost is excluded from Total Working Capital. What does this cost cover and why is it excluded from Working Capital needs?

77. The pro forma Balance Sheet shows no fixed assets, and depreciation is not included in the Statement of Revenues and Expenses, yet Section VIII: Capital Costs and Financing indicates purchases of furniture and equipment. This appears to be an inconsistency that understates operating expenses.

78. Section VI, Accessibility, item 2 indicates ISC will be accredited by CHAP. There is no explicit budget for accreditation expenses. How much expense is budgeted in the financial pro forma, and where is it included?

79. The Section IX Cash Flow statement indicates a Year 2 cash increase of $144,406, while the pro forma Balance Sheet indicates an increase of $29,075 ($53,238 Year 1 to $82,313 Year 2). ISC should explain this discrepancy.

80. ISC has projected that $698,407 in funding is required and it has a commitment of $800,000 from the parent, Brookdale. This is not an adequate funding commitment for short-term financial feasibility. ISC assumes Medicare certification will be obtained three months after the office opens. This is an unreasonable assumption for the reasons discussed above. Ten months to certification is a reasonable assumption. This means ISC will not receive seven months of HHA Medicare and Medicaid revenues it has assumed in Year 1. This will require an additional $200,000 in funding which exceeds the funding commitment by Brookdale. ISC has failed to show availability and commitment of necessary funds for its project and, thus, is not conforming with Criterion 5 (N.C. Gen. Stat. § 131E-183(a)(5)). ISC has further failed to show that its project is financially feasible in the short-run based on reasonable assumptions, again making its application not conforming with Criterion 5. If ISC has omitted bonuses and accreditation expenses from its pro forma, the shortfall in the funding commitment will be even larger.

SunCrest Home Health

81. SunCrest is a Tennessee-based company that currently provides no home health or other health services in Wake County or North Carolina. Other than development visits during the application process it has no relationships in Wake County on which to build its referral base of home health patients. SunCrest appears to offer no unique service or approach that would differentiate it from other HHAs and give it a comparative advantage in establishing itself in Wake County. The lack of relationships makes it less likely that it can realize its utilization projections than Community which has a well-established set of referral relationships with health care providers because of the many years it has provided hospice services in Wake County.

82. SunCrest's pattern of projected visits appears to show a mechanical, as opposed to individualized, approach to patient care. As Figure 6 below shows, the visits per patient by discipline are virtually the same for each discipline. SunCrest should explain why this pattern represents reasonable planning assumptions.

Figure 6[40]

Discipline	Visits	Duplicated Patients	Visits per Duplicated Patient
Nurse	3,482	799	4.4
Physical Therapist	2,399	553	4.3
Speech Therapist	220	55	4.0
Occupational Therapist	611	144	4.2
Medical Social Worker	149	37	4.0
Home Health Aide	750	184	4.1

83. Community has several questions and concerns about the financial data in the SunCrest application. The Assumptions for Balance Sheet and Cash Flows indicate additional capital expenditures of $24,900 in Year 1 and $10,000 in Year 2. What is the timing of these expenditures? Have they been included in the cash flow projections?

84. The costs for clinical staffing in Years 1 and 2 appear to be significantly understated.[41] The costs for physical therapy salaries and contract staff shown in the pro forma are as follows:

Year 1	Salaries	$ 90,865
	Contract	$ 42,764
	Total	$133,629

However, Section VII: Staffing indicates that the entire 2,182 PT visits projected for Year 1 will be covered by a contract physical therapist at $80 per visit, which totals $174,560.

Year 2	Salaries	$143,730
	Contract	$ 2,142
	Total	$145,872

Section VII: Staffing indicates that the 959 of the projected 2,399 PT visits projected for Year 1 will be covered by a contract physical therapist at $80 per visit, which totals $76,720. The remaining 1,440 visits equate to one PT FTE at $77,250. The total of these is $153,970.

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[40] SunCrest. 2010. CON Application. Section IV, Utilization, Table IV.2, p. 44.

[41] *Ibid.*, Pro forma PT salaries: Form B: Statement of Revenues and Expenses, p. 78;
Total PT visits: Section IV: Utilization, Table IV.2, p. 44;
Contract PT number of visits and fee: Section VII, Staffing, Tables VII.2, Year 1 and Year 2, p. 62.

85. Schedule IX: Start-Up and Initial Operating Expenses/Financing indicates that $350,000 of funding will come from line of credit borrowings, yet there is no interest included in the financial pro forma. Since this is incremental expense due to the new agency, even if the new agency will not pay the interest, it should be included in the financial pro forma and cash flow statements. The pro forma balance sheet includes debt.

86. Section VI, Accessibility, item 2 indicates SunCrest will be accredited by the Joint Commission. There is no discussion of the expenses for accreditation. How much expense is budgeted in the financial pro forma for accreditation, and where is it included?

87. The Section IX Cash Flow statement indicates a Year 2 cash increase of $70,723, while the pro forma Balance Sheet indicates an increase of $123,526 ($250,906 Year 1 to $374,432 Year 2). Other liabilities (debt?) increases $67,370, which doesn't explain the difference. SunCrest failed to explain this discrepancy. Also on this schedule for Year 1, the cash payments lines do not foot to total year.

88. SunCrest states Medicaid reimbursement using contractual adjustments instead of using 2010 North Carolina Medicaid reimbursement rates per discipline.

89. The Year 2 fourth quarter cash flow is negative. What causes this? How long is the projected negative cash flow expected to continue? Without knowing when cash flow will turn positive for the long-run, how can SunCrest know the funding it needs to commit to make the project financially feasible in the short-run?

90. SunCrest assumed that for the first two months of operations, any Medicare or Medicaid revenues would not be billable. This means SunCrest assumes Medicare certification after two months, which is an unreasonable assumption. A reasonable assumption is for Medicare certification ten months after the office opens. SunCrest projected that funding of $334,043 would be required to establish the HHA and it committed $450,000 in funds. However, the additional eight months without Medicare or Medicaid revenues will reduce Year 1 revenues by about $600,000 and increase the funds required accordingly. This exceeds the funds committed by SunCrest and shows the application is not financially feasible in the short-run. SunCrest has failed to show availability and commitment of necessary funds for its project and, thus, is not conforming with Criterion 5 (N.C. Gen. Stat. § 131E-183(a)(5)). SunCrest has further failed to show that its project is financially feasible in the short-run based on reasonable assumptions, again making its application not conforming with Criterion 5. Beyond the specific $450,000 commitment SunCrest makes general comments that it may be paraphrased as "whatever it takes." It is our understanding that such general statements do not constitute a commitment of funds, because if DHSR allowed this it would make the requirement of a funding commitment letter largely meaningless. For purpose of CON requirements we think SunCrest's commitment must be treated as an (inadequate) commitment of $450,000.

Home Healthcare & Hospice, Inc. (3HC)

91. This applicant has a well-established Medicare-certified HHA in Johnston County and currently has a way station in Wake County at the exact location it has proposed for the office of a Wake County HHA. Granting the same organization CONs for HHAs in both Johnston and Wake Counties is an unnecessary duplication of services because 3HC is currently able to deliver the same services to the same Wake County residents it would be able to serve with the CON.

92. According to the 3HC application, its Johnston County HHA served 300 Wake County residents in 2008 and 422 in 2009.[42] 3HC has had a home health office (non-Medicare certified) and a way station for its Johnston County HHA (Medicare-certified) at the same location for several years. That office was operated solely as a way station beginning December 15, 2008 and was moved to Donmoor Court in Garner on March 1, 2010. The current location of the way station is the same site where 3HC proposed to establish the Medicare certified HHA.[43] The number of Wake County residents 3HC projects it will serve from both its Johnston and Wake offices if its CON is approved is essentially the number it is serving now from its Johnston HHA.

93. Based on its own representations 3HC has a well-established home health business in Wake County and can expand this business without obtaining a separate CON for a Wake County office. 3HC projects it will serve about the same number of Wake County residents with or without the Wake County CON. Therefore granting 3HC the CON for Wake County would do nothing to meet the unmet need in Wake County identified in the 2010 SMFP.

94. 3HC's pattern of projected visits appears to show a mechanical, as opposed to individualized, approach to patient care. As Figure 7 below shows, the visits per patient by discipline are virtually the same for each discipline. 3HC should explain why this pattern represents reasonable planning assumptions.

Figure 7[44]

Discipline	Visits	Duplicated Patients	Visits per Duplicated Patient
Nurse	4,664	780	6.0
Physical Therapist	1,979	331	6.0
Speech Therapist	108	18	6.0
Occupational Therapist	464	78	5.9
Medical Social Worker	1,449	242	6.0
Home Health Aide	118	20	5.9

[42] 3HC. 2010. CON Application, p. 52.
[43] 3HC. 2010. CON Application, p. 12.
[44] Ibid., Section IV, Utilization, Table IV.2, p. 65.

95. Community has several questions and concerns about the financial assumptions in the 3HC application. While 3HC has included administrative costs in its pro forma, the costs in Table X.1: Cost per Visit by Year of Operation include only direct patient care and do not include administrative costs. Therefore these are not comparable to the other applications, which include ALL costs.

96. The cash flow statement is not reasonable. Cash receipts are projected as equal to net revenue and cash payments are projected as equal to total expenses. Payors never reimburse at the same time as revenue is billed; expenses are generally not all paid in the period incurred. Therefore projections of initial operating expenses based on these cash flow projections are not reasonable.

97. The applicant provides no assumptions for its revenue projections.

98. In Section VI, Accessibility, item 2 the applicant states it will become accredited by CHAP. However it does not discuss the expenses for accreditation or how much expense is budgeted in the pro forma, or where is it included. Given that 3HC can serve Wake County residents with its Johnston County HHA, which is already accredited, any expenditure by 3HC to separately accredit another HHA in Wake County is a waste of resources and of no benefit to the public.

99. The applicant has determined that only $140,000 is required to establish the Wake County HHA. This is because 3HC already has staff, a way station office and established referral sources for 422 Wake County patients. 3HC has committed $250,000 in funds to establish this HHA. 3HC also assumes the Wake HHA will be Medicare certified the day the office opens. That is not a reasonable assumption for the Wake County HHA. A reasonable assumption for certification of the new HHA with a new Medicare Provider Number is ten months. If 3HC plans to bill Medicare for services to Wake County residents through the Wake County HHA it has overstated Year 1 revenues by about $600,000 and it has not committed sufficient funds to make the Wake County HHA financially feasible in the short-run. 3HC has failed to show availability and commitment of necessary funds for its project and, thus, is not conforming with Criterion 5 (N.C. Gen. Stat. § 131E-183(a)(5)). 3HC has further failed to show that its project is financially feasible in the short-run based on reasonable assumptions, again making its application not conforming with Criterion 5.

100. Of course, as a prudent operator 3HC would not bill Medicare for home health services through the Wake County HHA in Year 1. It will continue to bill for these services through the Johnston HHA as it is doing now. Only after the Wake County HHA receives a Medicare Provider Number would 3HC bill for services to Wake County residents through the new agency. This once again shows how awarding 3HC the CON would accomplish nothing to meet the unmet needs in Wake County.

101. The only practical effect of awarding the CON to 3HC will be to prevent the entry of a new home health provider like CHHNC into the Wake County market. As an existing provider in Wake County, 3HC is part of the status quo that has led to unmet needs for services. DHSR should be focused on changing the status quo by picking the

best organization from among the applicants to increase the number of organizations offering home health services in Wake County. Awarding the CON to 3HC would not increase the number of organizations offering home health services in Wake County. In this batch of applications 3HC is clearly DHSR's worst choice.

Community Home Health of North Carolina, Inc. is the Superior Application

102. Having now had the opportunity to review the competing applications Community has a sound basis for concluding that CHHNC has submitted the superior application in the batch, and DHSR has a sound basis for awarding CHHNC the CON for a new Medicare certified Home Health Agency in Wake County.

- CHHNC is the only applicant that understands the realities of the accreditation and Medicare certification process, has made reasonable assumptions about the time required to obtain accreditation and has projected utilization, revenues, expenses and funds committed reasonably. No other applicant can satisfy Criterion 5.

- CHHNC will be a real addition to the home health providers in Wake County as we have no CON for a home health agency in an adjacent county that enables us to serve Wake County residents currently. Approval of CHHNC will be a real change in the status quo that addresses the unmet need.

- Since there are already two home health agencies in Wake County providing home health psychiatric care, and will soon be three agencies providing this service, CHHNC wisely choose not to initially offer this service. We found no documentation of unmet need, and we do not think it is practical for a start-up home health agency to provide this service. CHHNC will from our certification date accept referrals for patients with mental health diagnoses who need the services we are staffed to provide, including medication management. Should there be unmet needs for home health psychiatric care in the future, CHHNC would consider adding the necessary staff, but only after we are well-established and staffed to serve the 98.3+ percent of home health patients who do not need home health psychiatric care.

- Like all home health agencies, CHHNC will provide services 24 hours a day, 7 days a week. After normal business hours we will have a nurse on call to accept new referrals and to accept instructions and requests for established patients.

- Because of Mr. Roberson's common ownership of Community and Camellia Home Health and Hospice of Atlanta, CHHNC is backed by the experience, professional expertise and financial resources required for a successful start-up and successful operation.

- Because of Community's presence as a hospice provider in Wake County CHHNC will begin with a network of referral relationships and an excellent reputation for responsive, quality services. Several of the applicants have no service history and no existing relationships in Wake County.

- Based on its knowledge of conditions in Wake County, Community has identified the difficulties residents of rural areas of the county are having in finding a HHA to accept a referral. The evidence of this is found in the survey of Wake County physicians and other providers who make referrals to home health agencies. Our application documents how we will act to better serve rural residents.

- Community has made a major commitment to implement Electronic Health Records (EHR) to control costs and improve quality of care. After carefully researching multiple companies, Community has chosen McKesson to implement Horizon Hospice™, a comprehensive hospice software solution that follows a unique concept of care in which many different disciplines, working together, support not only the patient, but also family and friends surrounding the patient.

- CHHNC will offer a home health to hospice bridge program. This program will be designed to assist patients and their caregivers who are no longer eligible for home health, but who are terminally ill, transition to a palliative care program from rehabilitative home care. It may also be used for those hospice patients who are determined to no longer be eligible for hospice, but may be appropriate for home health. Nurses, therapists, social workers, and aides will work collaboratively with the hospice team to ensure continuity of care.

103. Community thanks DHSR staff for their consideration of these comments. We will be present at the public hearing on June 21 to answer any questions you may have.

Exhibit 1

CMS November 5, 2007 Memorandum on initial Surveys for New Medicare Providers

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-08-03

DATE: **November 5, 2007**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Initial Surveys for New Medicare Providers

Memorandum Summary

- The Centers for Medicare & Medicaid Services (CMS), together with States, seek to maintain effective quality assurance in the Medicare program at the same time that:
  - Many new providers are applying to participate in Medicare for the first time;
  - Resources are highly constrained since the President's proposed budget for Survey & Certification (S&C) has not been fully funded for the past three consecutive years;
- Appendix A therefore contains revised survey priorities and procedures to ensure that we obtain greater value from each survey dollar expended, and that CMS' priority structure for survey and certification activities are followed faithfully (see Appendix A);
- CMS longstanding policy makes complaint investigations, recertifications, and other core work for existing Medicare providers a higher priority compared with certification of new Medicare providers. We retain and affirm the advisability of those priorities;
- Providers that have the option of attaining accreditation that conveys deemed Medicare status conducted by a CMS-approved accreditation organization (in lieu of Medicare surveys by CMS or States) are advised that such deemed accreditation is likely to be the fastest route to certification;
- While accreditation by an accreditation organization does not suffice to demonstrate compliance with the special requirements for certain hospitals (such as rehabilitation or psychiatric hospitals or IPPS-excluded units) that receive payment outside of the Inpatient Prospective Payment System (IPPS), proper attestation of compliance with IPPS-exclusion requirements (combined with the accreditation) will permit the State and CMS to act expeditiously on the hospital's application.

Background

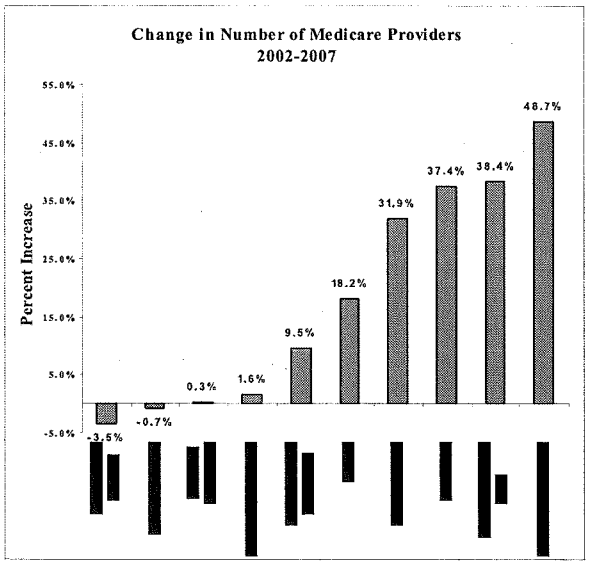
The Social Security Act (the Act) provides for a system of quality assurance in the Medicare program based on objective, onsite, outcome-based surveys by federal and State surveyors. The survey and certification (S&C) system provides beneficiaries with assurance that basic standards of quality are being met by health care providers or, if not met, that remedies are promptly implemented.

CMS accomplishes these vital quality assurance functions under specific direction from the Act and in concert with States, CMS-approved accreditation organizations (AOs), and various contracts with qualified organizations. All CMS or State certification surveys for Medicare must be performed by Medicare-qualified surveyors consistently applying federal regulations, protocols, and guidance. Most types of providers or suppliers seeking to participate in Medicare must first demonstrate compliance with quality of care and safety requirements through an on-site survey.

Initial surveys of new providers or suppliers have become more challenging for four reasons:

Resource Limitations: For the past three consecutive years the final federal budget for Medicare survey and certification has been considerably less than the level requested by the President. The FY 2007 appropriation, for example, was $25 million less than the President's budget request (and lower than FY 2005 levels). Although we remain hopeful that the FY 2008 appropriation will fully fund the President's request, it may be well into the fiscal year before Congress enacts the final FY 2008 budget.

***Many New Providers*:** Many additional providers have been seeking to participate in the Medicare program. Since 2002, for example, the number of Medicare-participating rural health clinics has increased by 48.7%, ambulatory surgical centers by 38.4%, hospices by 37.4%, home health agencies by 31.9%, dialysis facilities by 18.2%, and non-accredited hospitals by 9.5%. The graph to the right portrays the growth between 2002 and 2007 in the number of different providers and suppliers that constitute the main survey and certification workload.



***More Responsibilities*:** Additional survey responsibilities, such as new responsibility for surveys of hospital transplant programs beginning in late 2007, have further stretched survey resources and have increased the need to pay careful attention to survey priorities.

Anti-fraud Initiatives: Growth in the number of certain provider types, particularly home health, has been accompanied by evidence of higher levels of fraudulent activity by a minority of such providers. The Secretary's recent anti-fraud initiatives have called upon survey and certification to conduct additional surveys in certain areas where change of ownership indicates the need for closer review.

CMS Priorities

Longstanding CMS policy makes complaint investigations, recertifications, and core infrastructure work for existing Medicare providers a higher priority compared with certification of new Medicare providers. CMS directs States to prioritize federal survey functions in four priority "Tiers." Tier 1 consists of statutory mandates, such as surveys of existing nursing homes and home health agencies. Tier 4 consists of other important work, but work that is considered

reasonable to accomplish only if higher priority functions can be accomplished within the federal budget limitations.

Many provider or supplier types (such as hospitals, ambulatory surgery centers, hospices, and home health agencies), have the option of becoming Medicare-certified on the basis of accreditation by a CMS-approved AO instead of a survey by CMS or States. In such cases, the applicants have an alternate route to Medicare certification via CMS' acceptance of the AO's accreditation. While the applicant will pay a fee to the AO for the initial survey, applicants may conclude that the benefits outweigh the expense, particularly the expense of time waiting for a no-cost CMS survey. Similarly, clinical laboratory surveys are not subject to the CMS prioritization structure because the laboratories pay a fee to CMS for the laboratory certification work. For all initial Medicare surveys conducted by CMS or States, there is no cost to the applicant, but the resource limitations described here require that we adhere to a clear sense of priorities in conducting our work.

Most initial surveys for providers or suppliers seeking to participate in Medicare for the first time are prioritized in a lower priority (Tier 4) for CMS and State survey agency (SA) work compared to complaint investigations and recertification of existing providers or suppliers. The increasing severity of S&C resource limitations means that the effect of this longstanding CMS priority on providers and suppliers is more pronounced now than it has been in the past. The situation is different for each State, since some States have seen a large number of new providers seeking Medicare participation while other States have not seen such an increase.

Different providers/suppliers may also experience unique options and circumstances, so that a common policy may have a different impact on different providers. We are therefore refining the CMS policy for initial surveys in order to recognize the different situations being experienced by different providers and suppliers. The revised policy in **Appendix A** accomplishes a number of objectives:

- ***Process for Exceptions***: The revised policy explains the process by which providers or suppliers in certain unique circumstances may request from CMS an exception in their priority assignment.

- ***Higher Priority for Some Unique Situations:*** The "Tier 3" priority is expanded to raise the priority level for providers or suppliers in certain unusual circumstances without needing to request any special exception.

- ***Tier 4 Options:*** The revised policy offers a better explanation of the options available to providers whose application for new participation in Medicare represents a Tier 4 priority for survey and certification. These changes are particularly relevant to hospitals that offer services that are excluded from the Inpatient Prospective Payment System (IPPS). They provide methods by which proper attestation of compliance with IPPS-exclusion requirements (combined with the accreditation) will permit the State and CMS to act expeditiously on the hospital's application.

In the future, CMS will explore additional actions that may strengthen oversight of hospital rehabilitation and psychiatric services, including:

(a) Revising the Medicare hospital Conditions of Participation to include the special requirements for rehabilitation and psychiatric services that are now addressed only in the IPPS-exclusion requirements at 42 CFR 412, and
(b) Conducting onsite surveys for a sample of hospitals that provide rehabilitation or psychiatric services, based on an analysis of the degree to which there may be risk of noncompliance with the IPPS-exclusion requirements. Existing hospitals, as well as new hospitals, would be included in the sample.

Appendix B contains an example of content that may be useful in communicating these priorities to applicants.

Appendix C contains the addresses for all of the AOs whose accreditation we have deemed for Medicare certification purposes. Please convey this information to prospective providers or suppliers who have the option of deemed accreditation. Please note that some AOs offer accreditation for provider types for which deeming is not an option (either because deeming is not permitted under the law, or because no AO has submitted an approvable application to CMS). Examples include nursing homes and dialysis facilities. For each AO in Appendix C we have listed the provider or supplier types for which the AO's accreditation permits deemed status. If a provider or supplier type is not listed next to the name of a particular AO, then CMS does not deem such accreditation as meeting Medicare requirements.

Some provider types have the deemed accreditation option but an onsite CMS survey has been required to verify compliance with certain payment requirements related to exclusion from the inpatient prospective payment system (IPPS). The IPPS exclusion verification under 42 CFR 412 is a small but important aspect of the accreditation process for which the AO surveys are not deemed. To address this issue we are instituting a time-limited option process to treat the IPPS-exclusion verification for initial applications by signed attestation, the same manner in which such verification is handled for recertifications.

We hope this memorandum will assist States in both prioritizing survey work and in clearly communicating with providers and suppliers to understand:

- The reasons for CMS' priority structure for survey and certification work;
- The options that providers or suppliers have to obtain a survey that can establish their qualification to participate in Medicare;
- The length of time that may elapse before they may be surveyed, with as much certainty as possible given the annual federal budget and resource uncertainties. A clearer sense of the timeline will help providers and suppliers in better planning their efforts.

We request that States make the priority structure in Appendix A, and the procedures for providers that have an AO option, widely known to the provider/supplier community as soon as possible.

We hope the Appendix B potential content may be useful to assist States in offering prospective Medicare providers and suppliers with as much relevant information and timeline clarity as possible.

If you have any questions concerning this memorandum, please contact your CMS Regional Office.

Effective Date: The information contained in this memorandum is applicable immediately for all healthcare facilities that rely on CMS survey and certification work. The State Agency should disseminate this information within 30 days of the date of this memorandum.

Training: This information should be shared with all appropriate survey and certification staff, surveyors, and the affected provider community.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Appendix A
CMS Priorities for Initial Surveys of Providers and Suppliers Newly Enrolling in Medicare

I. Priority Exception Requests

Access to Care Reasons: Providers or suppliers may apply to the State survey agency (SA) for CMS consideration to grant an exception to the priority assignment of the initial survey if lack of Medicare certification would cause significant access-to-care problems for beneficiaries served by the provider or supplier. The State SA may choose whether to make a recommendation to CMS before forwarding the request to the CMS Regional Office (RO).

There is no special form required to make a priority exception request. However, the burden is on the applicant to provide data and other evidence that effectively establishes the probability of serious, adverse beneficiary health care access consequences if the provider is not enrolled to participate in Medicare. CMS will not endorse any request that fails to provide such evidence and fails to establish the special circumstances surrounding the provider's request. We expect that such exceptions will be infrequent.

II. Accreditation Requests

SAs should continue to collect and forward to the CMS RO the certification packets[1] for facilities wishing to participate in Medicare through deemed accreditation, including attestation documents for those facilities seeking first-time IPPS exclusion.

III. Tier 3

- ESRD Facilities – Due to the unique reliance of dialysis patients on Medicare, and the fact that there are no deemed accreditation options for ESRD facilities, we accord such facilities a higher (Tier 3) priority than most other provider or supplier types.

- Transplant Centers –Transplant centers are accorded the higher Tier 3 priority because there are no CMS-approved accrediting organizations (AOs) for transplant centers. While this may change in the future, CMS has neither received nor approved any AO applications for transplant center accreditation to date. In addition, transplant patients (and donors) rely on Medicare in ways that other patients do not (such as special eligibility provisions for post-operative immuno-suppressive drug coverage when certain otherwise ineligible individuals receive transplants from a Medicare-certified center).

- Hospitals without an AO Option. In this context it is necessary to distinguish the health and safety standards of the certification process for participation in Medicare from verification of compliance with the requirements for exclusion from the Inpatient Prospective Payment System (IPPS).

    - Verification of compliance with IPPS exclusion criteria by whole hospitals or excluded units of short term acute care hospitals is addressed in the discussion of Tier 4 priorities, part V of this Appendix.

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[1] Such as the completed provider agreement, applicable civil rights forms, completed worksheets where necessary, copy of the accreditation letter from the AO, etc.

- Surveys for the special psychiatric conditions of participation (CoPs) found at 42 CFR 482.60 through 482.62 will be done as a Tier 3 priority, typically by a CMS contractor. While psychiatric hospitals in general are eligible for deemed accreditation, no AO is approved for verification of compliance for the special psychiatric conditions of participation found at 42 CFR 482.60 through 482.62. We expect that the rest of the hospital's operations would achieve certification through deemed accreditation and that only the non-deemed part would be surveyed by the CMS as a Tier 3 priority.

- ***Critical Access Hospital (CAH) Distinct Part Units:*** A distinct part psychiatric or rehabilitation unit in a CAH must at this time rely on the higher Tier 3 priority, since the AO's currently approved for CAH certification have not been approved for deeming relative to such units. We anticipate that renewal applications by AOs to continue their authority for the CAH program will cover these distinct part units in the future. Only the distinct part unit(s) is eligible for Tier 3 priority, while the rest of the CAH has a deemed accreditation option. We will advise SAs when an AO has been approved to deem the distinct part units.

Note: Conversions of an existing provider under the same provider agreement- is not considered an initial application and the priority for initials does not apply. The provider/supplier types in this circumstance are:

- Conversion of a hospital to a CAH, or a CAH back to a hospital is a conversion (not an initial certification), and at State option may be done as Tier 2, 3, or 4. However, the addition of swing beds as a new service in an existing hospital or CAH is a Tier 4 priority, the same as a new nursing home service would be if it were started by a non-hospital.
- Similarly, the conversion of a Medicaid-only Nursing Facility (NF) to dual-certification (SNF/NF) does not require an initial certification survey and may be done at the State's discretion in accordance with SOM 7002.
- Nursing homes that convert to a Green House certified, resident-centered, culture change environment (which requires new construction).

IV. Tier 4

Accreditation Options: Initial certifications of all provider/supplier types that have the option to achieve deemed Medicare status by demonstrating compliance with Medicare health and safety standards through a survey conducted by a CMS-approved accreditation organization is a Tier 4 priority. In light of the federal Medicare resource constraints, we consider the cost of initial surveys to be the lowest priority for the Medicare program for those provider and supplier types that have a deemed accreditation option in those States unable to complete the higher-priority Tier 1-3 work.

Provider/supplier types with a Tier 4 priority for initial surveys because the have a deemed accreditation option include:

- Ambulatory Surgical Centers
- Home Health Agencies
- Hospices
- Hospitals
- Critical Access Hospitals

All Others: All other newly-applying providers/suppliers not listed in Tier 3 are Tier 4 priorities, unless approved on an exception basis by the CMS RO due to serious health care access considerations or similar special circumstances (see "Priority Exception Requests" above). The affected Medicare providers/suppliers include:

- Comprehensive Outpatient Rehabilitation Facilities
- Long Term Care Units in Hospitals
- Nursing Homes that do not participate in Medicaid
- Outpatient Physical Therapy
- Rural Health Clinics

V. Special Provisions for Compliance with IPPS-Exclusion Requirements

With respect to hospitals and CAHs, please note the following policy refinements:

1. Rehabilitation Hospitals: Rehabilitation hospitals are eligible for deemed accreditation, except for verification of the IPPS-exclusion requirements. Procedures for the IPPS-exclusion verifications are described below.

2. Psychiatric Hospitals: Psychiatric hospitals are eligible for deemed accreditation, except for the non-deemed special psychiatric CoPs at 42 CFR 482.60 through 482.62. While survey of the special conditions will be a Tier 3 priority for hospitals that have been otherwise deemed by an accreditation organization, survey for compliance with the rest of the hospital CoPs will remain a Tier 4 priority for CMS since the rest of the hospital survey may be accomplished by an AO.

3. IPPS-Excluded Rehabilitation Hospitals, and IPPS-excluded Rehabilitation or Psychiatric Units of a Hospital: Accreditation organizations do not have authority to verify a hospital's or a hospital excluded unit's compliance with the IPPS exclusion criteria at 42 CFR 412. Currently, annual re-verification of IPPS-exclusion for such excluded hospitals or units in already-certified hospitals is handled by provider self-attestation, but initial verification for first-time IPPS-exclusion has been required via certification surveys by the States.

Effective immediately we are suspending (until further notice) the requirement for an onsite IPPS-exclusion survey of all hospitals and units seeking first-time IPPS-exclusion (State Operations Manual (SOM) at section 3100 - 3108B), except for providers whose IPPS exclusion has previously been removed. Instead, such providers will be required to submit an attestation and completed Form CMS-437, CMS-437A or CMS-437B, whichever is applicable, indicating that all CMS exclusion requirements are met. Note that these attestation procedures apply to all hospitals and units that are IPPS-excluded.

In addition to the attestation and applicable Form CMS-437, rehabilitation hospitals and excluded rehabilitation units must also submit evidence of compliance with the medical director requirement. Psychiatric units must submit evidence of compliance with patient assessment and staffing requirements.

The following process will be used for IPPS-exclusion attestation and documentation:

(a) The SA will send to the provider the attestation statement and appropriate CMS-437, along with the standard packet of certification forms and documents, within 10 working days of the earlier of the following two dates:

- Receipt of the provider's letter of intent to open for service and to seek IPPS exclusion; or
- Receipt of the Fiscal Intermediary's recommendation for approval of the 855 application.

(b) In the case of rehabilitation hospitals or rehabilitation units, the SA will also request that the provider attach (to its completed certification packet) documentation that permits verification that the provider has a qualified medical director who meets the regulatory standards at 42 CFR 412.29(f).

(c) In the case of psychiatric units, the SA will also request that the provider attach to its completed certification packet the following information:
- Medical record protocols to permit verification that each patient receives a psychiatric evaluation within 60 hours of admission; that each patient has a comprehensive treatment plan; that progress notes are routinely recorded; and that each patient has discharge planning and a discharge summary.
- A description of the type and number of clinical staff, including a qualified medical director of inpatient psychiatric services and a qualified director of psychiatric nursing services, registered nurses, licensed practical nurses, and mental health workers to provide care necessary under their patients' active treatment plans.

(d) The provider should return the completed certification packet, along with all other requested materials, to the SA no less than 90 days prior to the start of the facility's first or next cost reporting period, as applicable, in order for the RO to have sufficient time to make a determination to approve or deny the provider's IPPS exclusion status. If the provider submits the application less than 90 days in advance, CMS will continue to process the application, but the provider assumes the risk that the RO review may not be completed in time for payment at the excluded rate to start with the first or next cost reporting period.

(e) The SA will act promptly to review the completed packet and will forward it to the RO as soon as possible in order to permit a final certification determination prior to the start of the provider's cost reporting period.

4. Psychiatric Unit or Rehabilitation Hospital/Unit IPPS Exclusion Removal: If CMS removes the IPPS exclusion status of a psychiatric unit or a rehabilitation hospital or unit, the hospital may subsequently seek excluded status again. In such cases the hospital is required to operate for at least twelve months under the IPPS while continuing to provide the applicable psychiatric or rehabilitation services that comply with the exclusion requirements.[2] The facility must apply for IPPS exclusion status in the same way as a provider seeking first-time exclusion. **However, in the case of a hospital or unit that has had its IPPS exclusion status removed, the requirement for <u>onsite</u> verification by the SA of compliance with the exclusion criteria for psychiatric or rehabilitation services will remain in force, and such surveys will be a Tier 4 priority.**

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[2] The twelve month requirement refers to the cost reporting period, and may be found at 42 CFR 412.25(c) and 412.25(f) for IPPS-excluded units of a hospital, and 42 CFR 412.23(h) and 412.23(i) for rehabilitation hospitals.

Appendix B - Example of Content for a Potential Provider Communication

Dear _____

We appreciate your request to be certified for participation in the Medicare program. Due to very substantial federal resource limitations, we must currently adhere to a careful priority schedule as we respond to requests from providers that newly seek to participate in Medicare. We hope this letter is helpful to you in understanding your options in this difficult situation.

Two independent and important steps in becoming a Medicare provider are:

Form CMS-855: Form CMS-855 contains background, contact, service, and provider or supplier information that is essential to the approval process. The applications are reviewed and recommended for approval or denial by the Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (MACs) under contract with the Centers for Medicare & Medicaid Services (CMS).

Certification: Most types of providers, and some suppliers, are required to demonstrate that they are in full compliance with Medicare quality and safety requirements. This demonstration is accomplished during an onsite survey conducted by trained and qualified surveyors from the State survey agency (SA) pursuant to an agreement with CMS. There is no charge to the provider or supplier for initial CMS surveys or any later CMS recertification survey. The CMS-855 must have been approved and the provider fully operational in order for a survey to be conducted.

Some provider/supplier types have the additional option to be accredited by a CMS-approved accreditation organization (AO), and such accreditation is "deemed" to be equivalent to a recommendation by the SA for CMS certification. The attached list provides contact information on each such AO, as well as information regarding the types of providers/suppliers for which deeming applies. Note that deeming does not apply to some provider types, such as nursing homes and dialysis facilities.

CMS instructs States to place a higher priority on recertification of existing providers, on complaint investigations, and on similar work for existing providers than for initial surveys of providers or suppliers newly seeking Medicare participation. **Due to severe resource limits for Medicare survey & certification functions, in most States few providers that have an AO option will be surveyed by CMS or the State.**

Short-term acute care hospitals, rehabilitation hospitals, critical access hospitals (but not their distinct part psychiatric and rehabilitation units), home health agencies, hospices, and ambulatory surgical centers all have the option of deemed accreditation. Applicants have the option of applying to one of the CMS-approved AOs. The attachment to this letter conveys the requisite contact information.

Providers may apply by letter to the SA for CMS consideration to grant an exception to the priority assignment of the initial survey if lack of Medicare certification would cause significant access-to-care problems for Medicare beneficiaries served by the provider or supplier. The SA may choose whether to make a recommendation to CMS before forwarding the request to CMS.

There is no special form required to make a priority exception request. However, the burden is on the applicant to provide data and other evidence that effectively establishes the probability of adverse beneficiary health care access consequences if the provider is not enrolled to participate in Medicare. CMS will not endorse any request that fails to provide such evidence and fails to establish the special circumstances surrounding the provider's or supplier's request.

CMS recognizes that special circumstances apply to certain types of providers or suppliers, and has made special priority allowances for them. Both dialysis facilities and transplant centers, for example, are afforded a higher priority compared to certain other providers/suppliers because there is no AO option available, end-stage renal disease patients and transplant patients have a unique reliance on Medicare for their care, and access is often an issue.

Hospitals that are applying for rehabilitation hospital status or for an IPPS-excluded unit(s) for rehabilitation and/or psychiatric services **and that have (or will have) attained AO accreditation from a CMS-approved AO for their general hospital operations** will be allowed to submit an attestation of compliance with Medicare requirements by their PPS-excluded unit(s). In addition, they will be required to complete a Form-437, Form-437A, or Form-437B, as applicable, in addition to the attestation. This will avoid the need for both an AO accreditation survey and an on-site PPS-verification survey by an SA, since there is no AO option for verification of such IPPS-excluded units. If you are in this situation, please communicate with the SA as early in the process as possible.

We regret that the resource limitations under which we operate may complicate the process of enrolling in Medicare as a certified provider or supplier.

Appendix C - CMS-Approved Accrediting Organization Contact Information CMS

Organization	Provider Type	Name	Address	Work Number	Fax Number	E-Mail Address
Joint Commission (JC)	Hospitals, HHAs, Hospice, ASCs, CAHs	Kurtz, Trisha	601 13th Street, NW Suite 1150N Washington, D.C. 20005	202-783-6655	202-783-6888	pkurtz@jcaho.org
	Labs	Steffens, Kathie Peck, Margaret	One Renaissance Boulevard Oakbrook Terrace, IL 60093	630-792-5785 630-792-5287	630-792-4885	ksteffens@jcaho.org mpeck@jcaho.org
American Osteopathic Association (AOA)	Hospitals, CAHs, ASCs	Reuther, George	142 East Ontario St Chicago, IL 60611-2864	312-202-8060	312-202-8360	greuther@hfap.org
	Hospitals, CAHs, ASCs	Beem, Karen	142 East Ontario St Chicago, IL 60611-2864	800-621-1773 Ext. 8066	312-202-8360	kbeem@hfap.org
	Labs	Thompson, Carol	142 E. Ontario St. Chicago, IL 60611	312-202-8070	312-202-8370	cthompson@hfap.org
Community Health Accreditation Program (CHAP)	HHAs, Hospice	Surrency, Gale	1300 19th Street NW Suite 150 Washington, D.C. 20036	202-862-3413 800-656-9656, ext. 12	202-862-3419	gsurrency@chapinc.org
Accreditation Association for Ambulatory Health Care (AAAHC)	ASCs	Gravesville, Meg	5200 Old Orchard Road Suite 200 Skokie, IL 60076	847-853-6073	847-853-9028	mgravesmill@aaahc.org
	ASCs	Villanueva, Michon	5200 Old Orchard Road Suite 200 Skokie, IL 60076	847-853-6063	847-853-9028	mvillanueva@aaahc.org
American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)	ASCs	Pearcy, Jeff	5101 Washington Street Suite 2F P.O. Box 9500 Gurnee, IL 60031	847-775-1970	847-775-1985	jeff@aaaasf.org
Accreditation Commission for Health Care, Inc (ACHC)	HHAs	Cesar, Tom	4700 Falls of the Neuse Rd Suite 280 Raleigh, NC 27609	919-785-1214	919-785-3011	tcesar@achc.org
American Society of Histocompatibility and Immunogenetics (ASHI)	Labs	McElroy, Melissa	90 West County Rd C Suite 300 St. Paul, MN 55117	651-487-2806	651-489-3387	Melissa@cmehelp.com

Organization	Provider Type	Name	Address	Work Number	Fax Number	E-Mail Address
	Labs	Zachary, Andrea Leffell, Mary	Johns Hopkins Immunogenetics Laboratory 2941 E. Monument St. Baltimore, MD 21205	410-955-3600	410-955-0431	aaz@jhmi.edu msl@jhmi.edu
College of American Pathologists (CAP)	Labs	Daniels, Amy Driscoll, Denise	325 Waukegan Northfield, IL 60093	847-832-7471 847-832-7243	847-832-8471	adaniel@cap.org ddrisco@cap.org
Commission on Laboratory Accreditation (COLA)	Labs	Harkins, Mina Patel, Alka	9881 Broken Land Pkwy Suite 200 Columbia, MD 21046	410-381-6581 X 500 410-381-6581 X 573	410-381-8611	mharkins@cola.org apatel@cola.org
American Association of Blood Banks (AABB)	Labs	Sullivan, Judy Rapp, Holly	8101 Glenbrook Rd Bethesda, MD 20814	301-215-6540 301-215-6523	301-907-6895	jsullivan@aabb.org Holly@aabb.org

Exhibit 2

April 30, 2010 E-mail Message from Ronald Clitherow, with Attachment

From: Ronald H. Clitherow [mailto:rhcheels@aol.com]
Sent: Friday, April 30, 2010 12:32 PM
To: rclitherow@larsonallen.com; RHCHEELS@aol.com
Cc: thillard@brookdaleliving.com; ncwilliams@uhs-pruitt.com; wlong@wellcarehealth.com; Daryl.Doise@LHCGroup.com; Anne Rivenbark; tbrooks@healthkeeperz.com; rgriffin@caresouth.com; russell.herring@assistedcare.net; rdecesare@phri.com; dlee@3hc.org
Subject: [SPAM]Offering Price Summary for Durham HHA Acquisition and "NextSteps"

Good morning to All,

Please see the attached price offering summary for the acquisition of the Durham County Home Health Agency which I indicated I would make available to you as soon as the public review period began. Included on the attachment are the initial price offerings as well as any amended price offerings that each organization was afforded the opportunity to submit. There were ten (10) organizations that submitted initial offering documents and Letters of Intent.

As you are aware, this transaction is a "public process" governed by North Carolina General Statute 131E-13. As part of this process, all offering documents are to be made available for public review for a period of of least ten (10) days. This time period began this morning, April 30, 2010 and documents are available in the office of the Clerk to the County Commissioners. Also, the County Commissioners are required to hold a Public Hearing on their previously adopted "Resolution of Intent." Should you desire to attend, the hearing will be held at 7:00 PM on May 10, 2010 in the County Commissioner chambers at the Durham County Courthouse (2nd Floor) located at 200 East Main Street in Durham, NC 27701 (this is the same location as the Clerks office). Typically at such hearings, there is a sign-up sheet for those wishing to speak and the Commissioners often ask for a briefing report from appropriate County officials who have been involved with this endeavor. At this meeting, the County Commissioners are not required to take any specific action, but may do so at their discretion, and/or, provide further "next step" guidance to the County Manger and staff as to their desires.

Since the amended price offering submission deadline of April 19, 2010, I have been in contact with each organization's designated representatives. Furthermore, at the direction of the Seller, I have had extensive discussions with the two (2) organizations that submitted the highest price offerings. Private, onsite interviews will be held with each of them next week with County administrative officials and myself. At this point, the County has not executed a Letter of Intent with any prospective buyer and it is likely this may not occur until after the Public Hearing. However, please remember that per the offering document requirements, all offering submissions must remain valid through June 30, 2010.

Thank you again for your interest, time and efforts in pursuing this opportunity to date. I have very much enjoyed working with each of you and will keep you updated as the process continues over the next several weeks. While these public acquisitions typically take longer than transactions between private parties, it remains the intent and desire of the Seller to move as quickly as possible to execute a mutually acceptable Letter of Intent such that the due diligence process and preparation of the Asset Purchase Agreement (APA) can proceed. Please note that the actual APA ("the conveyance" per G.S. 131E-13) must also be made available to the public for no less than ten (10) days prior to County Commissioner consideration for adoption. It remains the intent and desire of the Seller for this to be completed no later than June 30, 2010.

With warmest regards,

Ron

Ronald H. Clitherow, M.P.H.
Consultant, An Affiliate of
Larson Allen LLP
101 N. Tryon St., Suite 1000
Charlotte, NC 28246-0108
LarsonAllen Phone: 704-998-5239 (voice mail only)
Home Office Phone: 336-751-7297 (Preferred)
Home Office Fax: 336-751-3582
Email: rclitherow@larsonallen.com or rhcheels@aol.com

Durham Home Health Agency, d/b/a Visiting Nurse Service of Durham: Final Offering Price Summary

Offering Organization	Price Offering Original	Price Offering Amended
Brookdale Senior Living (BLC Acquisitions, Inc.	$2,650,000	$2,650,000
United Health Services of Georgia, Inc. (UHS-Pruitt-Parent Entity)	$2,000,000	$2,300,000
Well Care Home Health, Inc.	$1,400,000	$1,550,000
LHC Group, Inc.	$750,000	$1,500,000
Community Care, Inc.	$850,000	$1,500,000
HealthKeeperz, Inc.	$1,250,000	$1,250,000
CareSouth, Inc.	$400,000	$600,000
Assisted Care, Inc.	$550,000	$550,000
Primary Healthcare Resources, Inc.	$525,000	$525,000
Home Health and Hospice (3HC), Inc.	$150,000	$150,000

Initial Mean (Average) Offer Price:	$1,052,500
Initial Median Offer Price:	$800,000
Amended Mean (Average) Offer Price:	$1,242,500
Amended Median Offer Price:	$1,375,000

Exhibit 3
Palmetto GBA LCD for Home Health-Psychiatric Care (L265)

LCD for Home Health - Psychiatric Care (L265)

Contractor Information

Contractor Name

Palmetto GBA

Contractor Number

00380

Contractor Type

RHHI

LCD Information

LCD ID Number

L265

LCD Title

Home Health - Psychiatric Care

Contractor's Determination Number

98HH-002-L

AMA CPT / ADA CDT Copyright Statement

CMS National Coverage Policy

Title XVIII of the Social Security Act; §1862(a)(1)(A)allows coverage and payment for only those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

CMS Manual System, Pub. 100-01, Medicare General Information Eligibility, and Entitlement Manual, Chapter 4, §30.1

CMS Manual System, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 7, §40.1.2.15

CMS Manual System, Pub. 100- 08, Medicare Program Integrity Manual, Chapter 13, §§13.1.1-13.13.14

Primary Geographic Jurisdiction

Alabama
Arkansas
Florida
Georgia
Illinois

Indiana
Kentucky
Louisiana
Mississippi
North Carolina
New Mexico
Ohio
Oklahoma
South Carolina
Tennessee
Texas

Oversight Region

Region IV

Original Determination Effective Date

For services performed on or after 01/15/2000

Original Determination Ending Date

Revision Effective Date

For services performed on or after 05/13/2010

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

The evaluation, psychotherapy and teaching activities needed by patients suffering from a diagnosed psychiatric disorder that requires active treatment by a psychiatrically trained nurse may be covered as skilled nursing care. Patients may also require medical social services, occupational therapy, home health aide visits or other home health services related to the treatment of their psychiatric diagnosis.

1. The patient must be confined to the home.

"The condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving the home would require a considerable and taxing effort."

A patient with a psychiatric disorder is considered to be homebound "...if his/her illness is manifested in part by a refusal to leave the home, or is of such a nature that it would not be considered safe for him/her to leave home unattended even if he/she has no physical limitations." The following conditions support the homebound determination:

a. Agoraphobia, paranoia or panic disorder

b. Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairment of thoughts/cognition grossly affect the patient's judgement and decision making, and therefore the patient's safety

c. Acute depression with severe vegetative symptoms

d. Psychiatric problems associated with medical problems that render the patient homebound

"If a patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for relatively short duration, or are attributable to the need to receive medical treatment."

2. Services must be provided under a Home Health Plan of Care approved and signed by the treating physician.

3. Nursing services provided must meet the part-time or intermittent requirements for home health services. "In most instances, this definition wil be met if a patient requires a skilled nursing service at least every 60 days."

4. Services must be reasonable and necessary for treating the patient's psychiatric diagnosis and/or symptoms.

5. The services of a skilled psychiatric nurse must be required to provide the necessary care, i.e., observation/assessment, teaching/training activities, management and evaluation of a patient care plan, or direct patient care of a diagnosed psychiatric condition which may include behavioral/cognitive interventions.

Note: Psychiatric nursing must be furnished by an agency that does not primarily provide care and treatment of mental disorders. These agencies are precluded from participating as Medicare home health agencies.

QUALIFICATIONS FOR PSYCHIATRICALLY TRAINED NURESES PROVIDING PSYCHIATRIC EVALUATION AND THERAPY IN THE HOME

1. Nurses who provide psychiatric evaluation and therapy as skilled nursing care to patients of a home health agency are required to have special training and/or experience beyond the standard curriculum required for an RN.

2. Palmetto GBA would consider the special training and/or experience requirements to be met, if the registered nurse (RN) meets one of the following criteria:

a. An RN with a Master's degree with a specialty in psychiatric or mental health nursing and licensed in the state where practicing would qualify. The RN must have nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.

b. An RN with a Bachelor's degree in nursing and licensed in the state where practicing would qualify. The RN must have one year of recent nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.

c. An RN with a Diploma or Associate degree in nursing and licensed in the state where practicing would qualify. The RN must have two years of recent nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.

d. An RN who has worked as a psychiatric Home Health (HH) Nurse within the last calendar year prior to the effective date of this policy will be grandfathered in.

3. On an individual basis, other combinations of education and experience may be considered.

4. It is highly recommended that psychiatric RNs also have medical/surgical nursing experience because many psychiatric patients meet homebound criteria due to a physical illness.

5. Home Health agencies should 1) submit the resume of any nurse currently providing psychiatric services under the Home Health Medicare benefit, 2) submit the resume of any RN that will be providing psychiatric services under the Home Health Medicare benefit. Send the resume to the following address:

Palmetto Government Benefits Administrators

Medical Affairs, Part A

Mail Code AG-300

P. O. Box 100238

Columbia, SC 29202-3238

The resume will be reviewed and you will be notified if the RN meets the requirements or not within 30 days. ***Note:** This notification should be in your files prior to the RN rendering psychiatric services.

6. Nurses with these qualifications would meet the requirements necessary to provide psychiatric evaluation and therapy to Medicare home health patients. The services of a psychiatric nurse are to be provided under a plan of care established and reviewed by the treating physician.

7. For additional information, see the ***BILLING WHEN SEPARATE VISITS WERE MADE FOR MEDICAL AND PSYCHIATRIC NURSING CARE*** section of this policy.

Diagnostic Criteria

1. A Patient must have an Axis I Diagnosis as defined in the Diagnostic and Statistical Manual of Mental Health Disorders, 4th Edition, DSM-IV-TR. This diagnosis must match the diagnosis that the ordering physician is treating and/or for which the patient was hospitalized. This diagnosis must be fully documented and available in the medical record.

The DSM-IV-TR utilizes a multiaxial assessment methodology and "Axis I" is defined as "Clinical disorders, other conditions that may be a focus of clinical assessment" as opposed to personality disorders, mental retardation, general medical conditions, psychosocial and environmental problems and global assessment of functioning.

2. The patient must be under the care of a physician who is qualified to sign the physician's certification and recertify the plan of care at least every 60 days (two months). The physician's evaluation and subsequent recertifications must become part of the patient's medical record.

3. If the skills of a psychiatric RN are required, the service must be reasonable and necessary and intermittent.

4. Reasonable goals must be established and there must be a reasonable expectation that the goals will be achieved. Decreasing and/or shortening in-patient and emergency room care may be a goal for the psychiatric patient's plan of care.

Home Health Plan of Care

The Plan of Care for a psychiatric patient must be completed. Emphasis must be placed on documentation of mental status and those skills necessary to treat the psychiatric diagnosis.

Psychiatric Interdisciplinary Team's Role

Physician:

1. Certifies/Recertifies the patient's homebound status

2. Approves Home Health Plan of Care which must be signed and dated prior to the home health agency billing for services.

3. Prescribes medications as necessary

4. Provides supplemental orders when medically necessary

Skilled Nursing Care:

Registered Psychiatric Nurse:

1. Makes initial assessment visit utilizing observation/assessment skills

2. Manages medical illness; performs psychobiological interventions

3. Evaluates, teaches and reviews medications and compliance; administers IM or IV medication

4. Manages situational or other crises; performs assessments of potential self harm or harm to others, and refers to the treating physicians as necessary

5. Teaches self-care, mental and physical well-being, promotes independence and patient's rights

6. Promotes and encourages patient/caregiver to maintain a therapeutic environment

7. Provides supportive counseling psychotherapy and psychotherapeutic interventions according to education and licensure. Provides psychoeducation such as teaching/training with disease process, symptom and safety management, coping skills and problem solving

8. Provides evaluation and management of the patient's care plan

9. Counseling services may be rendered by either a trained psychiatric nurse or a social worker. These services should not be duplicative. Concurrent counseling or psychotherapy services by multiple providers are not medically necessary

10. Although intervention with family members may be appropriate on occasion, services by a trained psychiatric nurse to family members are not a covered home health benefit, even if the patient will benefit.

Medical Social Services

Medical social services provided by a qualified medical social worker (MSW) or a social work assistant under the supervision of a qualified MSW, may be covered as home health services when **all** of following apply:

1. The patient meets the qualifying criteria for coverage og Home Health services.

2. The services of these professionals are necessary to resolve social or emotional problems which are, or are expected to be, an impediment to the effective treatment of the patient's psychiatric condition or his/her rate of recovery.

3. The plan of care clearly indicates that the skills of a qualified MSW (or a social worker assistant under the supervision of a qualified MSW) are required to safely and effectively provide the needed care.

When the above requirements are met, coverage for social worker visits may include, but are not limited to the following:

1. Assessment of the social and emotional factors related to the patient's illness, the need for care, response to treatment and adjustment to care

2. Assessment of the relationship of the patient's medical and nursing requirements to the individual's home situation, financial resources and availability of community resources

3. Counseling services that are required by the patient for the treatment of their psychiatric condition (Psychotherapy services, constituting active treatment of the psychiatric condition, may be provided by licensed clinical social workers.)

4. Brief counseling (two or three visits) of the patient's family or care-giver(s) when they are reasonable and necessary to resolve problems that are a clear and direct impediment to the treatment of patient's illness or injury or rate of recovery

5. Appropriate action to obtain available community resources to assist in resolving the patient's problem

Note: Medicare **does not** cover the services of an MSW to assist in filing the application for Medicaid or follow up on the application. Federal regulation requires the state to provide assistance in completing the application to anyone who chooses to apply for Medicaid.

Note: A patient may require separate and distinct services provided by a skilled psychiatric nurse and a medical social worker. However, care must be used to avoid duplication of services that could be provided by both of these disciplines, e.g., counseling of the patient.

Home Health Aide (HHA)

Home health aids may perform personal care or other covered home health aide services.

Occupational Therapist (OT)

1. The skills of an occupational therapist may be required to decrease or eliminate limitations in functional activity imposed by psychiatric illness or disability. Occupational therapists may address factors which interfere with the performance of specific functional activities due to cognitive, sensory, psychosocial or perceptual deficits.

2. The skills of an occupational therapist to assess and reassess a patient's rehabilitation needs and potential or to develop and/or implement an occupational therapy plan are covered when they are reasonable and necessary because of the patient's condition.

3. The planning, implementing and supervision of therapeutic programs (including, but not limited to those listed below) are skilled occupational therapy services. As such these services are covered if they are reasonable and necessary for the treatment of the patient's illness or injury.

a. Selecting and teaching task oriented therapeutic activities designed to restore and increase cognitive abilities and functional participation in ADLs and advanced ADLs

b. Planning, implementing and supervising therapeutic tasks and activities designed to restore sensory-integrative function

c. Planning, implementing and supervising of individualized therapeutic activity programs (as well as adapting the environment) as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness

d. Assessing and planning for improved home safety

Billing When Separate Visits Were Made for Medical and Psychiatric Nursing Care

Psychiatric nursing care is not separately billable from non-psychiatric nursing care. Both of these services constitute skilled nursing care and may be furnished by the psychiatric nurse, in the course of a single visit. Therefore, visits will not be covered for one nurse to provide psychiatric nursing care and another to provide non-psychiatric nursing care, unless the non-psychiatric nursing care is of such a highly specialized and technical nature, that the service could not be safely rendered by the psychiatric nurse (e.g. infusion therapy).

Concurrent Admission to Home Health and Partial Hospitalization Program

Because Partial Hospitalization services are intended to meet all of the patient's psychiatric care needs, patients admitted to a Partial Hospitalization Program (PHP) are not generally considered appropriate for psychiatric home health services. Medical necessity must be substantiated on a case by case basis. If there are concurrent admissions, the home health claims will be reviewed to verify the medical necessity of the service(s) provided and that the homebound criterion is met.

Discharge Criteria

Patients should cease receiving psychiatric home health services when:

1. Physician orders discharge

2. Patient discontinues/refuses service with physician or nurse

3. Patient is not compliant with the treatment plan, despite appropriate provider interventions

4. Patient/family requests discharge

5. The treatment objectives and stated functional outcome goals have been attained or are no longer attainable

6. The patient is no longer homebound

7. Other appropriate discharge protocols, e.g., the patient moves or is transferring to another agency, etc.

Psychiatric Nursing in Group Setting

Group interventions for psychiatric home health patients are not covered under the home health benefit. The plan of care and treatment must be individualized.

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

32x	HHA-inpatient or home health visits (Part B only)
33x	HHA-outpatient (HHA-A also)

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

0430	Occupational therapy-general classification
0550	Skilled nursing-general classification
0560	Medical social services-general classification
0570	Home health aid (home health)-general classification

CPT/HCPCS Codes

As of July 1999, Home Health agencies must use the following HCPCS codes when billing for Home Health services provider under a plan of treatment. These services must report time spent with the patient in 15-minute increments.

G0152	SERVICES OF AN OCCUPATIONAL THERAPIST IN HOME HEALTH OR HOSPICE SETTINGS, EACH 15 MINUTES
G0154	SERVICES OF SKILLED NURSE IN HOME HEALTH, OR NURSE IN HOSPICE SETTINGS, EACH 15 MINUTES
G0155	SERVICES OF CLINICAL SOCIAL WORKER IN HOME HEALTH OR HOSPICE SETTINGS, EACH 15 MINUTES
G0156	SERVICES OF HOME HEALTH/HOSPICE AIDE IN HOME HEALTH OR HOSPICE SETTINGS, EACH 15 MINUTES

ICD-9 Codes that Support Medical Necessity

Patients must have Axis I Diagnosis as defined in the DSM-IV-TR.

290.11	PRESENILE DEMENTIA WITH DELIRIUM
290.12	PRESENILE DEMENTIA WITH DELUSIONAL FEATURES
290.13	PRESENILE DEMENTIA WITH DEPRESSIVE FEATURES
290.20	SENILE DEMENTIA WITH DELUSIONAL FEATURES
290.21	SENILE DEMENTIA WITH DEPRESSIVE FEATURES
290.3	SENILE DEMENTIA WITH DELIRIUM
290.41	VASCULAR DEMENTIA, WITH DELIRIUM
290.42	VASCULAR DEMENTIA, WITH DELUSIONS
290.43	VASCULAR DEMENTIA, WITH DEPRESSED MOOD
291.0	ALCOHOL WITHDRAWAL DELIRIUM
291.1	ALCOHOL-INDUCED PERSISTING AMNESTIC DISORDER
291.2	ALCOHOL-INDUCED PERSISTING DEMENTIA
291.81	ALCOHOL WITHDRAWAL
291.89	OTHER SPECIFIED ALCOHOL-INDUCED MENTAL DISORDERS
292.0	DRUG WITHDRAWAL
292.11	DRUG-INDUCED PSYCHOTIC DISORDER WITH DELUSIONS
292.12	DRUG-INDUCED PSYCHOTIC DISORDER WITH HALLUCINATIONS
292.2	PATHOLOGICAL DRUG INTOXICATION
292.81 - 292.84	DRUG-INDUCED DELIRIUM - DRUG-INDUCED MOOD DISORDER
292.85	DRUG INDUCED SLEEP DISORDERS
292.89	OTHER SPECIFIED DRUG-INDUCED MENTAL DISORDERS
292.9	UNSPECIFIED DRUG-INDUCED MENTAL DISORDER
293.81 - 293.84	PSYCHOTIC DISORDER WITH DELUSIONS IN CONDITIONS CLASSIFIED ELSEWHERE - ANXIETY DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE
293.89	OTHER SPECIFIED TRANSIENT MENTAL DISORDERS DUE TO CONDITIONS CLASSIFIED ELSEWHERE, OTHER
293.9	UNSPECIFIED TRANSIENT MENTAL DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE

294.0	AMNESTIC DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE
294.11	DEMENTIA IN CONDITIONS CLASSIFIED ELSEWHERE WITH BEHAVIORAL DISTURBANCE
294.8	OTHER PERSISTENT MENTAL DISORDERS DUE TO CONDITIONS CLASSIFIED ELSEWHERE
295.00	SIMPLE TYPE SCHIZOPHRENIA UNSPECIFIED STATE
295.01 - 295.04	SIMPLE TYPE SCHIZOPHRENIA SUBCHRONIC STATE - SIMPLE TYPE SCHIZOPHRENIA CHRONIC STATE WITH ACUTE EXACERBATION
295.10	DISORGANIZED TYPE SCHIZOPHRENIA UNSPECIFIED STATE
295.11 - 295.14	DISORGANIZED TYPE SCHIZOPHRENIA SUBCHRONIC STATE - DISORGANIZED TYPE SCHIZOPHRENIA CHRONIC STATE WITH ACUTE EXACERBATION
295.30	PARANOID TYPE SCHIZOPHRENIA UNSPECIFIED STATE
295.31 - 295.34	PARANOID TYPE SCHIZOPHRENIA SUBCHRONIC STATE - PARANOID TYPE SCHIZOPHRENIA CHRONIC STATE WITH ACUTE EXACERBATION
295.40 - 295.45	SCHIZOPHRENIFORM DISORDER, UNSPECIFIED - SCHIZOPHRENIFORM DISORDER, IN REMISSION
295.50 - 295.55	LATENT SCHIZOPHRENIA UNSPECIFIED STATE - LATENT SCHIZOPHRENIA IN REMISSION
295.70	SCHIZOAFFECTIVE DISORDER, UNSPECIFIED
295.71 - 295.74	SCHIZOAFFECTIVE DISORDER, SUBCHRONIC - SCHIZOAFFECTIVE DISORDER, CHRONIC WITH ACUTE EXACERBATION
295.75	SCHIZOAFFECTIVE DISORDER, IN REMISSION
296.01 - 296.05	BIPOLAR I DISORDER, SINGLE MANIC EPISODE, MILD - BIPOLAR I DISORDER, SINGLE MANIC EPISODE, IN PARTIAL OR UNSPECIFIED REMISSION
296.11 - 296.15	MANIC AFFECTIVE DISORDER RECURRENT EPISODE MILD DEGREE - MANIC AFFECTIVE DISORDER RECURRENT EPISODE IN PARTIAL OR UNSPECIFIED REMISSION
296.21 - 296.25	MAJOR DEPRESSIVE AFFECTIVE DISORDER SINGLE EPISODE MILD DEGREE - MAJOR DEPRESSIVE AFFECTIVE DISORDER SINGLE EPISODE IN PARTIAL OR UNSPECIFIED REMISSION
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296.41 - 296.45	BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) MANIC, MILD - BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) MANIC, IN PARTIAL OR UNSPECIFIED REMISSION
296.51 - 296.55	BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) DEPRESSED, MILD - BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) DEPRESSED, IN PARTIAL OR UNSPECIFIED REMISSION
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	ANXIETY STATE UNSPECIFIED - UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER
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331.2	SENILE DEGENERATION OF BRAIN
331.82	DEMENTIA WITH LEWY BODIES
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333.71	ATHETOID CEREBRAL PALSY
333.72	ACUTE DYSTONIA DUE TO DRUGS
333.85	SUBACUTE DYSKINESIA DUE TO DRUGS
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333.92	NEUROLEPTIC MALIGNANT SYNDROME
333.94	RESTLESS LEGS SYNDROME
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Diagnoses that Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

General Information

Documentation Requirements

1. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to the Intermediary upon request.

2. Documentation should address the diagnoses and interventions identified on the Plan of Care.

3. Documentation should be brief and factual. Use descriptive charting: be problem-specific.

4. Documentation should clearly support the medical necessity for services.

5. Each visit note should include documentation of any psychiatric or medical assessment, an evaluation of the patient's mental status, level of function and progress toward goals. Document objectively when describing behaviors and/or findings.

6. Document changes in the patient's condition and the actions taken, e.g., notification of the physician.

7. Document the assessment of home milieu and supportive environment.

8.Teaching has to be directed to improving function. Document identified teaching needs in response to psychiatric symptoms. Document all patient/family education, the reason for education, what was taught, and the patient's response. If repetitive teaching is required, documentation must clearly show the medical necessity of that teaching.

9. Document the patient's understanding and compliance of the medication regimen and treatment plan, and how verified.

10. Document the administration of IM and/or IV medications, their effectiveness, and any side effects of the patient's medication regime.

11. Document patient safety issues.

12. Documentation should show that periodic venipuncture for blood levels for psychiatric medications, such as Lithium, Tegretol, Clozaril and others, and other related laboratory work, are performed when necessary and pertinent reports of results are in the medical record. This ensures patient compliance and appropriate therapeutic levels.

13. Clinical documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

14. The person rendering the service must sign each visit note. If psychiatric services were rendered it must have been performed by a psychiatric RN, and their resume must have been reviewed and approved by Palmetto GBA.

Appendices

Utilization Guidelines

1. Psychiatric skilled nursing care must be provided by a credential nurse (Services will be denied if their psychiatric credentials are not on file with Palmetto GBA.)

2. For patient's with Alzheimer's disease please refer to the Local Coverage Determination (LCD) Home Health Skilled Nursing Care-Teaching and Training Alzheimer's Disease and Behavioral Disturbances 05HH-001-L/L19817.

Sources of Information and Basis for Decision

Diagnostic and Statistical Manual of Mental Health Disorders, 4th Edition, DSM-IV, American Psychiatric Association, 1995

IASD Health Services Corporation policy on Home Health Psychiatric Care, 9/1/96

Diagnostic and Statistical Manual of Mental Health Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

Advisory Committee Meeting Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rest with the Intermediary, this policy was developed in cooperation with advisory groups, with includes representatives from the Home Health provider community and RHHI Clinical Workgroup. Advisory Committee Meeting Date: N/A.

Start Date of Comment Period

08/26/1998

End Date of Comment Period

07/15/1999

Start Date of Notice Period

12/15/1999

Revision History Number

Revision #19, 05/13/2010
Revision #18, 09/11/2009
Revision #17, 03/26/2009
Revision #16, 08/14/2008
Revision #15, 01/04/2008
Revision #14, 09/06/2007
Revision #13, 10/01/2006
Revision #12, 03/22/2006
Revision #11, 11/16/2005
Revision #10, 05/20/2005
Revision #9, 11/22/2004
Revision #8 10/01/2004
Revision #7 11/28/2003
Revision #6 10/17/2003
Revision #5 10/01/2003
Revision #4 10/08/2002
Revision #3 07/08/2002
Revision #2 10/10/2001
Revision #1 07/25/2000

Revision History Explanation

Revision #19, 05/13/2010

This LCD has had its annual validation and no changes were made. The annual validation is completed. This revision becomes effective 05/13/2010.

Revision #18, 09/11/2009
Under ***CMS National Coverage Policy*** section CMS Manual System, Pub 100-08, Medicare Program Integrity, Transmittal 63, Change Request 3010, dated January 23, 2004, was changed to CMS Manual System, Pub 100-08, Medicare Program Integrity Manual, Chapter 13, §§13.1.1-13.13.14. The annual validation is completed. This revision becomes effective 09/11/2009.

Revision #17, 03/26/2009
Under ***CMS National Coverage Policy*** the following citation was added:
CMS Manual System, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 7, §40.1.2.15

Under ***Indications and Limitations of Coverage and/or Medical Necessity*** section the statement under Home Health Aids (HHA) was rewritten to be a complete sentence.

Under ***ICD-9 Codes That Support Medical Necessity*** the following ICD-9 codes were added: 291.1, 291.2, 292.85, 292.89, 294.0, 294.11, 294.8, 295.40-295.45, 295.50-295.55, 295.75, 296.7, 296.80, 296.81, 296.89, 296.90, 296.99, 331.11, 331.19, 331.2 and 331.82.

Under ***Documentation Requirements*** statement #14 was changed to read, "The person rendering the services must sign each visit note. If psychiatric services were rendered it must have been performed by a psychiatric RN, and their resume must have been reviewed and approved by Palmetto GBA."

Under ***Utilization Guidelines*** added the Local Coverage Determination (LCD) that addresses skilled services for an Alzheimer's patient.

These changes become effective on 03/26/2009.

Revision #16, 08/14/2008
This LCD has had its annual review. No changes were made. This revision becomes effective on 08/14/2008.

Revision #15, 01/04/2008
Under ***CMS National coverage Policy*** section the following citations were deleted:

CMS Manual System, Pub 100- 2, Medicare Benefit Policy Manual, Chapter 7, §§20, 30, 30.1.1, 30.1.2, 30.2.1, 30.2.3, 30.2.4, 30.2.5, 30.2.6, 30.2.7, 30.2.8, 30.3, 30.4, 40, 40.1.3, 40.1.2.15, 40.2.1, 50.1, 50.2, 50.3, and 50.7

Under ***Indications and Limitations of Coverage and/or Medical Necessity*** section the *"Qualifications for Psychiatrically Trained Nurses Providing Psychiatric Evaluation and Therapy in the Home"* the address was changed from PO Box 7004, Camden, SC 29020 to PO Box 100238, Columbia, SC 29202-3238.

These changes become effective on 01/04/2008.

Revision #14, 09/06/2007
Under ***AMA/CPT & ADA/CDT Copyright Statement*** the copyright date was changed to 2007.

Under ***CMS National Coverage Policy*** section the word "section" was replaced with "§". The manual numbers were changed from 100-1 to 100-01, etc.

The changes become effective on 09/06/2007.

Revision #13, 10/01/2006
Under ***Indications and Limitations of Coverage and/or Medical Necessity*** section of the policy, the manual citations through out the verbiage have been removed. For manual citations, refer to the section titled ***CMS National Coverage Policy***. Under the ***ICD-9 Codes That Support medical Necessity*** the ICD-9 code 333.7 has been expanded to a 5th digit. The new codes are 333.71 and 333.72. Also added were 333.85 and 333.94. The word contractor was replaced with the word Intermediary in the ***Advisory Committee Meeting Notes*** section. These changes become effective on 10/01/2006.

Revision #12, 03/22/2006
Under CMS National Coverage Policy section of the policy the following manual citations have been deleted. CMS Manual System, Pub. 100-2, Medicare Benefit Policy, Chapter 7, Sections 30.1, 30.2, and 40.2. These citations were added to the policy, CMS Manual System, Pub. 100-2, Medicare Benefit Policy, Chapter 7, Sections 30.1.2, 30.2.1, and 30.4. Under Indications and Limitations of Coverage and/or Medical Necessity section of the policy the zip code for mailing psychiatric nurse's resumes changed from 29020 to 29021.These changes become effective 03/22/2006.

Revision #11, 11/16/2005
Under ICD-9 Codes That Support Medical Necessity section of the policy, ICD-9 codes 295.00, 295.10, 295.30, and 295.70 have been added. These changes become effective on 11/16/2005.

Revision #10, 05/20/2005
This policy was converted to an LCD per instructions in Change Request 3010 as cited under CMS National Coverage Policy section of this policy. Also the citation of 42 CFR Chapter 1, Subpart A, General Prevision was deleted. These changes become effective on 05/20/2005.

Revision #9, 11/22/2004
Under AMA CPT Copyright Statement section of this policy, deleted references to CDT-4 copyright language, as this policy does not contain CDT-4 codes or descriptions. This revision becomes effective 11/22/2004.

Revision #8, 10/01/2004
Under AMA CPT Copyright Statement section of this policy the copyright date has been updated from 2003 to 2004. Per CMS the Dental copyright was added. Under CMS National Coverage Policy section the citation for the CFR has been changed to 42 CFR Chapter 1, Subpart A, General Provision. The following citations have been deleted. CMS Manual System, Pub. 100-2, Medicare Benefit Policy, Chapter 7, Section 50. The following citations have been added to the policy. CMS Manual System, Pub. 100-2, Medicare Benefit Policy, Chapter 7, Sections 30.1.1, 30.2.2, 30.2.3, 30.2.4, 30.2.5, 30.2.6, 30.2.7, and 30.2.8. Under the Indications and Limitations of Coverage and/or Medical Necessity section in the policy, the section titled Physician #2 the statement "Stamped signatures are not acceptable" has been deleted. Under CPT/HCPCS Codes section the CPT code G0152, G0154, G0155 and G0156 were added. Under ICD-9 Codes That Support Medical Necessity there were many verbiage changes to the ICD-9 codes. The ICD-9 codes with verbiage changes are 290.41, 290.42, 290.43, 291.89, 292.0, 292.11, 292.12, 293.81, 293.82, 293.83, 293.84, 293.89, 293.9, 296.01-296.05, 296.41-296.45, 296.51-296.55, 296.61-296.65, 299.00-299.01, 299.10-299.11, and 299.80-299.81. These changes become effective 10/01/2004.

Revision #7, 11/28/2003
Under CMS National Coverage Policy section of this policy the manual citations have been changed to reflect the Internet Only Manual (IOM). These changes are effective 11/28/03

Revision #6 10/17/2003 Correction of a typographical error. ICD-9-CM code 300.0-300.9 should be 300.00-300.9. This change is effective immediately.

Revision #5 10/01/2003 Under AMA CPT Copyright Statement section of this the date has been changed from 2002 to 2003. This change become effective 10/01/2003.

Revision #4 10/08/2002-Revision to Primary Geographic Jurisdiction and CMS Region
Revision #3 07/08/2002-ICD-9 code 295.7 has been added to the policy
Revision #2 10/10/2001-ICD-9 code 292.8 has been updated to 292.81-292.84
Revision #1 07/25/2000
This LCD was converted from an LMRP on 5/10/2005

Reason for Change

ICD9 Addition/Deletion

Last Reviewed On Date

04/22/2010

Related Documents

This LCD has no Related Documents.

LCD Attachments

There are no attachments for this LCD.

All Versions

Updated on 05/06/2010 with effective dates 05/13/2010 - N/A

Updated on 11/15/2009 with effective dates 09/11/2009 - 05/12/2010

Updated on 08/10/2009 with effective dates 09/11/2009 - N/A

Updated on 03/18/2009 with effective dates 03/26/2009 - 09/10/2009

Updated on 08/05/2008 with effective dates 08/14/2008 - 03/25/2009

Updated on 12/19/2007 with effective dates 01/04/2008 - 08/13/2008

Exhibit 4
Exhibit 57 to United's CON Application

Exhibit 57

Exhibit

Estimated Number of Wake County Home Health Clients in Need of Psychiatric Services

		2011	2012	2013	2014
a	Estimated Total Wake County Home Health Need (Clients)	15,203	16,547	18,013	19,571
b	Percent of Clients in Need of Psychiatric Care	3%	3%	3%	3%
c	Estimated Wake County Home Health Pyschiatric Need (clients)	455	495	539	586

d	2006 discharges per 10,000 residents over 65	3507	35%
e	North Carolina mental health admissions for persons over 65 per 100,000 residents	1917	
e	Wake LME mental health admissions per 100,000 residents	577	
f	Ratio of Wake LME to state		54.7%
e	NC over 65 admissions per 1000 mental health 2008	19.17	
g	Estimated Wake LME admissions per 1000 , mental disorders, over age 65	10.49	1%
h	Percent of Wake County hospitalizations over 65 attributed to mental disorders		3%

Sources:

a Section III.1.(b).
b See note h
c a*b
d http://www.cdc.gov/nchs/data/nhsr/nhsr005.pdf Hospital Utilization
e http://www.dhhs.state.nc.us/MHDDSAS/statspublications/reports/lme09annualrpt.pdf
North Carolina LMES Annual Statistics and Admissions Report FY 2009
f Wake LME / State in e above
g f * e
h g / d

Assumptions:

1 Mental health admits to home health will have had a prior hospital admission.
2 Home health is dominated by persons over 65, so hospital admissions by that demographic are the better measure of psychiatric need.

Exhibit 5

Understanding Joint Commission's Home Health and Hospice Deemed Status Option

Understanding Joint Commission's Home Health and Hospice Deemed Status Option

A Q&A Guide Covering Federal Deemed Status and State Recognition

The Joint Commission
Accreditation
Home Care

TABLE OF CONTENTS

What is federal deemed status?

For your Home Health Agency or Hospice to participate in and receive payment from the Medicare or Medicaid programs, you must be certified as complying with the standards, called Conditions of Participation, set forth in federal regulations. This certification is usually based on a survey conducted by a state agency on behalf of the Center for Medicare/Medicaid (CMS).

However, if a national accrediting organization has and enforces standards that meet the federal Conditions of Participation, CMS may grant that organization "deeming" authority to conduct these types of surveys and "deem" each subsequently accredited health care organization as meeting the Medicare and Medicaid certification requirements.

The health care organization would have "deemed status" and would not be subject to a separate Medicare survey and certification process conducted by the state.

If you select the deemed status option and your Joint Commission accreditation survey is successful, The Joint Commission recommends to CMS that you receive Medicare certification.

CMS makes the final determination on whether or not your organization will be Medicare certified. CMS retains the authority to conduct random validation surveys and complaint investigations for Medicare certified organizations.

What are the advantages of choosing a deemed status survey?

The deemed status option offers several advantages. First, accreditation by The Joint Commission is recognized nationwide as a "seal of approval" which indicates that an organization meets certain performance standards.

Accreditation offers many benefits, including:

- Improved patient care
- Improved business processes
- Strengthened community confidence in your organization
- Professional consultation and enhanced staff education
- Recognition and expedited payment from insurers and other third party payers
- Enhanced risk management

Second, The Joint Commission is actively working to reduce survey duplication on behalf of health care providers. The deemed status option is one way of combining compliance activities and reducing duplicative regulatory surveys.

? *Is my organization eligible for a deemed status survey option?*

To participate in a Joint Commission deemed status survey, you must first meet *both* The Joint Commission and Medicare's eligibility criteria as a home health agency or a hospice.

Joint Commission Hospice Eligibility. An organized program that consists of services provided and coordinated by an interdisciplinary team to meet the needs of patients who are diagnosed with a terminal illness and have a limited life span. The program specializes in palliative management of pain and other physical symptoms, meeting the psychosocial and spiritual needs of the patient and the patient's family or other primary care person(s), utilization of volunteers and provision of bereavement care to survivors. This includes, but is not limited to; all programs licensed as hospices, and Medicare-certified hospice programs. All services provided by the hospice (e.g., pharmacy and HME services), and care provided in all settings (in-patient, nursing home, etc.) are included.

Medicare Hospice Eligibility. Hospice care is an approach to caring for terminally ill individuals that stresses palliative care (relief of pain and uncomfortable symptoms), as opposed to curative care. In addition to meeting the patient's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the patient, as well as the psychosocial needs of the patient's family/caregiver.

Joint Commission Home Health Eligibility. The provision of any health care services by health care professionals to patients in their place of residence. This includes, but is not limited to, performing assessments, provision of care, treatment, counseling, and/or monitoring of the patient's clinical status by nurses (both intermittent skilled and private duty), occupational therapists, physical therapists, speech-language pathologists, audiologists, social workers, dietitians, dentists, physicians, and other licensed health care professionals in the patient's home. It includes the extension or follow-up of health care services provided by hospital professional staff in the patient's home.

Medicare Home Health Definition. A Medicare-certified home health agency is one in which part-time or intermittent skilled nursing services and at least one other therapeutic service (physical, speech, or occupational therapy; medical social services; or home health aide services) are made available on a visiting basis, in a place of residence used as a patient's home. An HHA must provide at least one of the qualifying services directly through agency employees, but may provide the second qualifying service and additional services under arrangements with another agency or organization.

Is there a minimum number of patients my organization needs to have in order to be eligible for a deemed status survey to be conducted?

Yes.

We require home health agencies to have serviced at least 10 patients in the last 12 months and have 7 active at the time their onsite survey is conducted.

We require hospice agencies to have serviced at least 5 patients in the last 12 months and have 3 active at the time their onsite survey is conducted.

My organization is already Joint Commission accredited and would like to move forward with this option for survey. What do we do?

Because this is a voluntary option, *you must elect deemed status in writing.*

If you are a currently accredited Joint Commission organization and would like to select this option, you may indicate your choice to The Joint Commission in one of two ways: complete the form provided in the application or email or write to The Joint Commission before your survey is conducted.

The letter, addressed to your Account Representative in Accreditation Operations, should include the following:

- your agency's decision to elect the deemed status survey option;
- your Medicare provider number, and whether you are a home health agency, hospice, or both;
- the date of your most recent Medicare survey; and
- the date of your previous Joint Commission survey.

Once you make the decision to select the deemed status option, you will want to inform your state of your decision to use the Joint Commission process. You will need to provide the Joint Commission with the copy of the letter you sent your state

DOH. This will decrease the possibility of a state surveyor arriving to conduct the routine Medicare survey prior to The Joint Commission.

The CMS form HCFA-855a (Medicare General Enrollment Health Care Provide/Supplier Application) must be filed and accepted by the state agency as well. This can be found on the CMS website, under the "forms" section. You will need to provide us a copy of the acceptance letter from CMS.

We also suggest contacting your Account Executive by phone to verify the written information has been successfully received and to discuss any additional questions you may have. Their main number is 630.792.3007.

? ***I am not Joint Commission accredited and would like to select this option. How do I apply?***

After verifying that your organization meets the eligibility requirements and necessary patient volumes, you can request access to the application at www.jointcommission.org/applicationhomecare.

You will then receive an email within 3-5 business days containing your password to access and complete the application on our website www.jointcommission.org, at Joint Commission Connect.

The following steps need to be completed before new organizations can have a survey scheduled:

- The CMS form HCFA-855a (Medicare General Enrollment Health Care Provide/Supplier Application) must be filed and accepted by the state agency. These can be found on the CMS website under the "forms" section. You will need to provide us with the acceptance letter from CMS.
- For initial certification for home health agencies, demonstration of successful transmission of OASIS data to the state agency.
- If required to have a state license, and the state does not recognize Joint Commission accreditation for state licensure, verification of state licensure.
- Submit a letter to the state agency indicating the organization's intent to use The Joint Commission's survey process for Medicare certification.
- A $1700 application deposit must be paid. Contact our pricing unit to pay by credit card or check, 630.792.5665.

Please also be sure to complete the Joint Commission application with the same information provided in the CMS 855 form (company name, services provided, etc.) to minimize any delays in communication between The Joint Commission and CMS regarding your completed survey results.

? *How does a deemed status survey differ from a regular Joint Commission survey?*

The surveyors conducting deemed status surveys have been specially trained to evaluate Medicare Conditions of Participation (CoPs) and standards in addition to Joint Commission standards within the on-site survey. CMS requires that home visits and record reviews are conducted according to their established protocols.

If you have been through a previous accreditation survey by The Joint Commission, you will see minor differences in the on-site review. Typically the on-site deemed status survey is a day or two longer in length than a traditional accreditation survey. The on-site survey length is on average 3 days for home health agencies and 4 days for hospices.

Important to note: CMS requires that home health agencies to pass an initial survey, in addition to two interim surveys with no conditional-level deficiencies over a three year period. Once this has been satisfied, organizations can resume a triennial on-site survey cycle.

? *If our hospice or home health agency is part of another organization, is deemed status still an option?*

The deemed status option is available to any hospice or home health agency that meets The Joint Commission and CMS eligibility, regardless of whether it is free standing or part of a hospital, long term care facility, or provides other home care services, including pharmaceutical services or medical equipment.

? *If we are already accredited, are we automatically granted deemed status?*

No, Medicare deemed status is not granted automatically to already-accredited organizations, nor is it granted retroactively. If you are in the middle of a triennial survey cycle with The Joint Commission and wish to add Medicare deemed status email or write to The Joint Commission addressed to your Account Representative and request a deemed status survey outside of your normal triennial cycle. This survey will be unannounced, and will only cover Medicare's Conditions of

Participation requirements. Renewal of the deemed status option at the time of your regular triennial resurvey will again be your choice.

Does deemed status apply to state surveys?

While federal deemed status does not provide an exemption from current state requirements for state licensure, The Joint Commission's various accreditation programs are recognized and relied on by many states in the states' quality oversight activities. Recognition and reliance refer to the acceptance of, requirement for, or other reference to the use of Joint Commission accreditation, in whole or in part, by one or more government agencies exercising regulatory authority. Recognition and reliance may include use of accreditation for licensing, certification or contracting purposes by various state agencies.

As of February 1, 2009, the following states accepted Joint Commission home care accreditation for licensure requirements for hospice: Arizona, Georgia, Iowa, Montana, Nebraska, New Jersey, Ohio, Oregon, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin, and Wyoming.

As of February 1, 2009, the following states accepted Joint Commission home care accreditation for licensure requirements for home health agencies: Arizona, California, Connecticut (contracting for services from Department of Social Services), Florida (accreditation required for new licensure), Georgia, Missouri (private-duty nursing care for children from the Department of Social Services), Montana, Nebraska, North Carolina, Ohio (waiver providers), Oklahoma, Rhode Island (enhanced reimbursement), Tennessee, Texas, Utah, Virginia, Washington and Wyoming.

How much does a deemed status survey cost?

Hospice

If your hospice decides to have The Joint Commission conduct a Medicare survey in conjunction with your Joint Commission accreditation survey, there will be no added charge for the Medicare survey.

Home Health

If your home health agency elects to have The Joint Commission conduct a deemed status survey, you will be charged an additional fee. The fees are based upon your patient volumes (average daily census or ADC) and number of locations.

Please contact our pricing unit for a no obligation quote at 630.792.5115.

How soon can we be accredited, and can we request specific dates for our survey?

For an initial survey, it is possible to be surveyed as soon as four months from the date your application and non-refundable deposit are processed by The Joint Commission.

Because of the unannounced requirement, we cannot accept requests for *specific* survey dates. However, for organizations preparing for their first accreditation survey, you may denote a "ready month" on your application to us. This means a Joint Commission surveyor will not visit your organization before then allowing you time to prepare.

If you are already Joint Commission accredited, your regular, triennial survey will be scheduled within an 18-39 month window before or after your 3-year Joint Commission accreditation anniversary date. If you elect to continue the deemed status option for your next survey, the exact survey date will remain unannounced.

What steps should I take to prepare my organization for a deemed status survey?

Inform your organization of your intent to move forward with accreditation.

Assemble a small team of key individuals within your organization who can work collaboratively to review accreditation requirements and identify those you may not currently be meeting. Prepare for your accreditation survey using the *Comprehensive Accreditation Manual for Home Care* as your guide book. We suggest:

Read each of the standards applicable to your services. Pay special attention to the element of performance (EP) of each applicable where additional requirements for those organizations seeking deemed status are noted. Review carefully the direct impact standards and those noted below.

LD.04.01.01 (situational rule)
HR.01.02.07 (situational rule)
LS.01.01.01 (situational rule)
HR.01.02.05
HR.01.06.01
IC.01.06.01
APR.09.01.01

Review the current National Patient Safety Goals

Educate and train your staff

Use the PPR tool as a means to conduct an internal "mock survey" with staff

Other tips

Designate a central location to house the necessary documentation you need to have on hand to show the surveyor when the come to visit. Make sure all key staff know where this is.

Implement a system to quickly reach key staff that you'll use the day the surveyor arrives. Practice and test it prior to the ready date you noted on your application to us.

Contact the Standards Interpretation Group to clarify questions you have about a standards or accreditation requirement at 630.792.5900

Consider attending a formal education course. Joint Commission Resources Inc. hosts a variety of seminars and publishes preparation materials you may find useful. Check their website for their most recent offerings www.jcrinc.com.

Who will survey our organization?

If you are a hospice, your surveyor will be a registered nurse with specific experience providing hospice care. He or she will also have a BSN or master's degree, and will have completed specific training related to the hospice Medicare Conditions of Participation.

If you are a home health agency, your surveyor will also be a registered nurse who is experienced in Medicare requirements for a home health agency, both in direct practice and additional training related to the home health Conditions of Participation. As with hospice, the nurse will have either a bachelor's or master's degree.

What will be included in our accreditation report?

After the completion of the on-site survey you will receive a summary of findings. The surveyor will also explain the procedures and time frames necessary for submitting evidence of standards compliance if any standards are found to be out of compliance.

In addition, you will also receive an accreditation decision report from The Joint Commission central office which will include the final conclusions including any deficiencies in meeting the Conditions of Participation.

What information is provided to CMS about our survey?

A copy of the Accreditation Decision Report (that is, the same report you have already received) and, if requested by CMS, survey forms and any CMS form completed by the surveyor during the onsite survey process is forwarded to CMS.

The Joint Commission is required to notify CMS of organizations that have received provisional accreditation, conditional accreditation, preliminary denial of accreditation, and denial of accreditation.

The release of this information is authorized by the written consent of the accredited organization as part of the "deemed status election form."

Who can we call if we have questions about a particular standard or accreditation requirement?

Please contact our Standards Interpretation Group at 630.792.5900 or online via our website, www.jointcommission.org. Look for the online standards form to send your question by email.

Who can we call if we have general questions about if this option is right for our organization?

You are welcome to contact our Home Care Accreditation team at 630.792.5251 with any questions.

If you are already accredited, we encourage you to contact your account representative at 630.792.3007 or their direct line to learn more.

Updated: 9/24/09

Exhibit 6
ISC Website Pages, Viewed May 2010

Care3 Wellness
ISC Careers

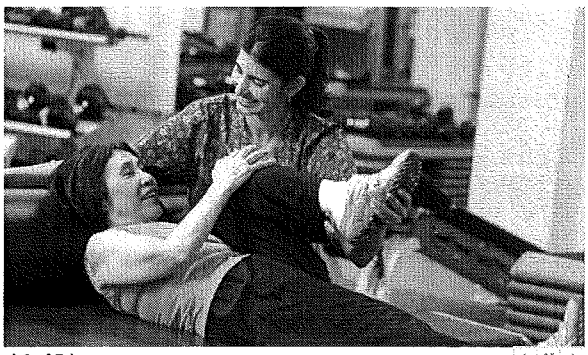
Find A Community

Enter - City

Select - State

Find Now

Innovative Senior Care (ISC)



(6 of 7)

Featured Links

ISC Brochure (PDF)

ISC Careers

Find a Community

INNOVATIVE SENIOR CARE by BROOKDALE

Innovative Senior Care[SM] (ISC) is committed to making the lives of our senior residents more meaningful and enriched. Our Care3 Wellness programs help minimize the effects of aging by providing treatments promoting functional independence, improving overall health and techniques for preventing pain and disability.

You can be part of a team that integrates both proactive and reactive services to help our residents enhance their health and fitness and retain or improve their independence, through a full continuum of rehabilitation services from Skilled Inpatient Rehab to Home Health Nursing/Therapy to Outpatient Therapy. These services are provided through a variety of different senior living environments from Independent Living, Assisted Living and Memory Care communities.

Education, Skilled Home Health Nursing, Home Health/Outpatient Rehabilitation and exercise are the key ingredients to our Care3 Wellness Program. These services are proactive in nature and use a holistic approach that aims to prevent accident, injury or more acute levels of care. ISC has designed its programs to meet the needs of the senior population and focuses on hiring nurses and therapists with a true affinity for working with seniors.

At ISC, Our goal is to treat not just the effects of the aging process, but to also educate residents about healthy aging. This allows our residents to become their own health advocates, striving to reach their highest level of functional independence. ISC goes far beyond traditional Home Health and Therapy to include less conventional, but highly beneficial means of rehabilitation massage therapy, chair yoga, and Tai Chi, as well as health education and group exercise classes.

At Brookdale Senior Living, we believe that health and wellness can be achieved at any stage in life and our goal is not only to increase one's quantity of life, but also the quality of life.

Care3 Wellnes Program

Innovative Senior Care Careers

NOTE: Innovative Senior Care and Care3 Wellness Services are available at most, but not all Brookdale Senior Living communities. Please check with individual communities for local availability of these services.

Partners Walgreens ALFA

Care3 Wellness
ISC Careers

Find A Community

Enter - City

Select - State

Find Now

ISC Careers

Search ISC Careers

Join Innovative Senior Care for a great work environment, the opportunity to build your career, and to enjoy a fulfilling experience!

Innovative Senior Care (ISC), part of Brookdale Senior Living, has a large client base and uses nursing, therapy and wellness techniques to provide lifestyle enhancements for residents of senior living communities. Our services enable residents to live better by helping them to be safer, healthier, more mobile and more vibrant at any age or level of health and fitness. Our comprehensive home health, rehabilitation, wellness and education services include Medicare-certified Inpatient therapy, Home Health nursing/therapy and Outpatient physical, occupational, and speech therapy. Taken together, these services provide an unparalleled continuum of care offering within a premier senior living environment.

As an ISC associate, you will receive a portfolio of impressive benefits designed to help you provide a comfortable lifestyle for yourself and your family. These include:

- Flexible Spending Account
- 401k
- Tuition Reimbursement
- Medical Benefits
- Dental
- Short-term Disability
- Life Insurance
- Paid Time Off
- Vision
- Long-term Disability
- Associate Life Program
- Continuing Education
- More!

Major Medical, Dental, Vision, Flexible Spending Account, Short-term Disability Long-term Disability, 401k, Life Insurance Associate Life Program, Tuition Reimbursement, Paid Time Off, Continuing Education, First Day Medical Benefits, Unmatched Retention Bonus Plan, and More!

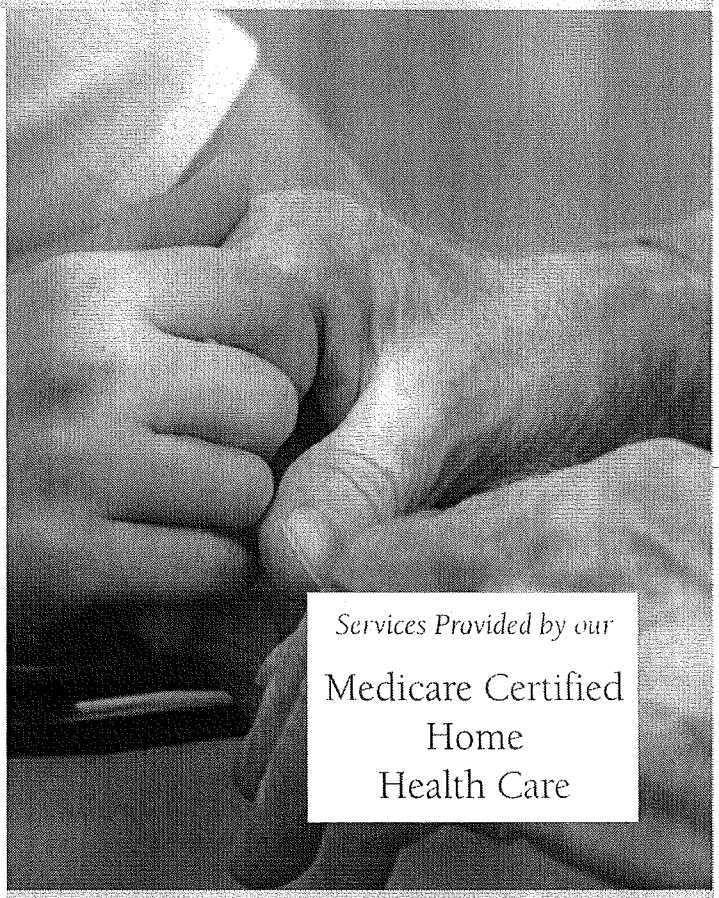
Innovative Senior Care is the innovative opportunity for Nursing, Physical, Occupational, and Speech Therapy Careers. PRN opportunities available for MSW and HH Aides as well.

Contact us today and let's begin building your career!

INNOVATIVE
SENIOR CARE
by Brookdale
Home Care

"Services shall be provided to all persons without regard to race, color, creed, sex, national origin, disability, sexual orientation, age, marital status, status with regard to public assistance or veteran status. All services are available without distinction to all individuals admitted, regardless of their diagnosis. Agency shall not deny admission to people with a contagious disease, including, but not limited to, HIV, MRSA and Hepatitis."

INNOVATIVE
SENIOR CARE
by Brookdale
Home Care



Services Provided by our

Medicare Certified Home Health Care

INNOVATIVE
SENIOR CARE
by Brookdale
Home Care

ABOUT ISC HOME HEALTH

ISC Home Care is a Medicare Certified home health agency committed to providing high quality, multidisciplinary home health services delivered by an experienced team of healthcare professionals. Our goal is to develop an individualized plan of care, under the direct supervision of a physician, to return our patients to a life of medical independence as quickly as possible.

MEDICARE ELIGIBILITY

If you are a Medicare beneficiary and require skilled care, home health services may be paid at 100% no cost to you if you meet the following requirements:

- Home health services must be ordered by your physician and medically necessary
- You need skilled care from licensed caregivers
- You need short-term or intermittent care
- You are homebound

HOME HEALTH CARE SERVICES

- Skilled Nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Worker
- Home Health Aide

NURSING

- Wound Care
- Teaching and training for specified disease processes and procedures
- Observation and assessment after a change in your medical condition
- Medication changes/teaching/monitoring
- Injections
- Catheter Maintenance

THERAPY

- Orthopedic rehab
  (fractures, joint replacements, etc.)
- Neurological rehab
  (stroke, brain injury)
- Balance disorders
- Dysphagia/aphasia
- Home management skills
- Adaptive/assistive equipment
- ADL retraining

MEDICAL SOCIAL WORKER

- Community resource planning

HOME HEALTH AIDE

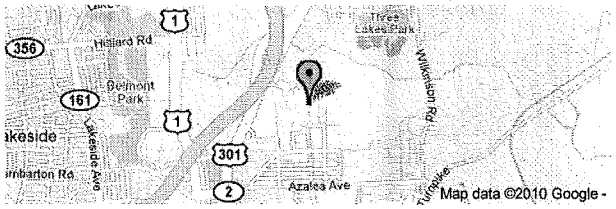
- Assistance with bathing and personal care

Exhibit 7
ISC Jobseeker—Richmond, Virginia Web Pages

Search Criteria: No Search Criteria

Job Title: Assistant Director of Home Health Professional Services
Job Number: HHADPSrichVA090914a
Environment:
Job Type: Full Time
Pay Range: DOE - DOE Annual
Relocation: N
VISA Sponsorship:
Travel: Minimal
Number of Openings: 1
Opportunity:

Location: Richmond,VA,23227



Innovative Senior Care, part of Brookdale Senior Living, has an outstanding opportunity for a RN to serve as the Assistant Director of Home Health Professional Services of their home health agency in their upscale retirement communities in the Richmond, VA area.

The Assistant Director of Home Health Professional Services is a registered professional nurse who is responsible for the oversight and coordination of the RN Case Managers as well as the operational support for the Director of Home Health Professional Services (DPS). The Assistant Director of Home Health Professional Services is responsible for the delivery of services across care teams, ensuring care is coordinated as ordered, complying with company standards as well as state and federal guidelines.

Brookdale Senior Living Inc., a publicly traded company (NYSE: BKD), is the largest senior living provider in the United States. Brookdale□s geographic spread, depth of talent, resources and access to capital are unmatched in the industry. Brookdale operates 550 locations in 35 states and employees approximately 27,500 full and part time employees serve nearly 52,000 residents.

If you want a rewarding career enhancing the lives of others, we invite you to consider Brookdale Senior Living company. Learn more about BKD at www.brookdaleliving.com or go to www.innovativeseniorcare.com for a complete listing of our career opportunities.

Immediate Opening: Assistant Director of Home Health Professional Services
Onsite Home Health Agency Serving Upscale Retirement Communities!

Job Type: Full Time

Medical Benefits Start Day One ~ No waiting period! Great compensation package!

Location: Richmond, VA

For more information, contact Pamela Krbec 888-409-8347or send resume to pamelakrbec@brookdaleliving.com . Please include the job number in the subject line of the e-mail: **HHADPSrichVA090914a**. You can also apply via our web site www.innovativeseniorcare.com. EOE/DFWP

RN, registered nurse, nurse, branch manager, clinical supervisor, assistant director of nursing, director of professional services, hospice, DON, home health, home care, Richmond, Midlothian, VA, Virginia

1. Must be registered nurse in good standing in the state of Virginia.
2. Minimum 3 years experience as a registered nurse with at least 2 years in home health.
3. Must have management experience.
4. Must have experience in a Medicare home health.
5. Must be skilled in OASIS and ICD-9 coding.
6. Computer skills a plus.

Benefits:

Health Insurance, Life Insurance, Dental Insurance, Disability Insurance, Paid Vacation, Paid Sick Leave, 401(k), Bonus Plan, Tuition Reimbursement, Paid Time Off

Apply Section

If this is the first time you've applied with us.

- Simply press **Apply** to continue with the next step in the Job Application Process for all the jobs that are marked.

If you've applied with us before.

- Enter the e-mail address and password that you chose for identification. This allows us to pre-fill the Application form with your previous information.
- Press **Apply** to continue the process for all the jobs that are marked.

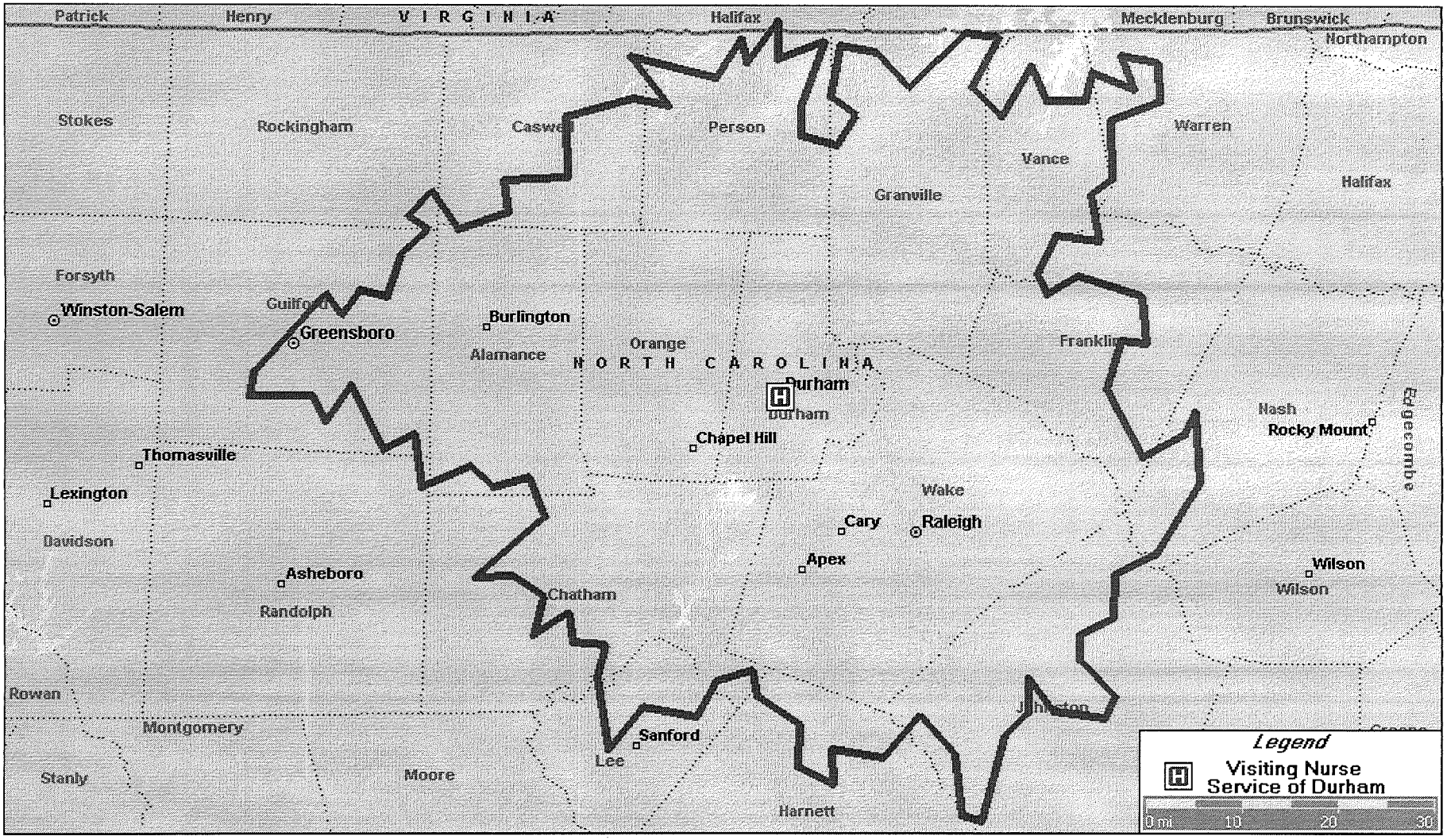
E-Mail: Password:

Email My Password

Apply Email This Job To A Friend

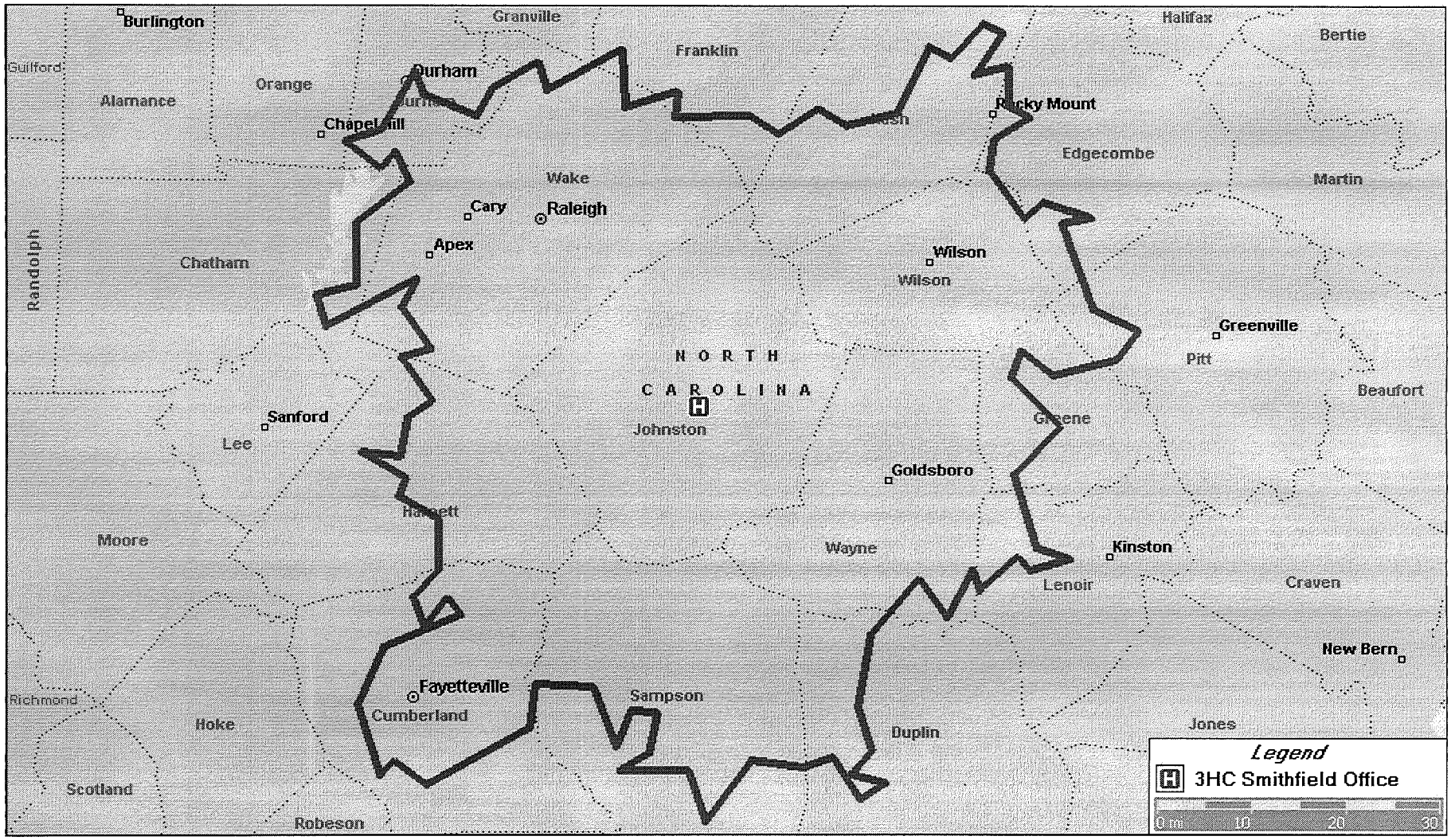
Exhibit 8
60 Minute Drive Time Maps

Visiting Nurse Service of Durham, 60 Minute Drive Time Zone



Source: Microsoft MapPoint 2009

3HC Smithfield Office, 60 Minute Drive Time Zone



Source: Microsoft MapPoint 2009