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October 31, 2020

Gregory F. Yakaboski, Project Analyst
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
North Carolina Department of Health and Human Services
809 Ruggles Drive
Raleigh, North Carolina 27603

RE: Comments on Rowan County Hospice Home Care Office CON Applications

Dear Mr. Yakaboski:

Enclosed please find comments prepared by Carolina Caring, Inc. regarding the competing CON applications for one new Hospice Home Care Office to meet the Rowan County need identified in the *2020 State Medical Facilities Plan*. Thank you for the opportunity to submit these comments for consideration regarding this important community need.

If you have any questions about the information presented here, please contact me at 828.469.2224.

Sincerely,

David W. Cook

David W. Cook
President/Chief Executive Officer
Carolina Caring, Inc.

WRITTEN COMMENTS ABOUT COMPETING CERTIFICATE OF NEED APPLICATIONS

ROWAN COUNTY HOSPICE HOME CARE OFFICE

Submitted by Carolina Caring, Inc.
October 31, 2020

Eight applicants submitted Certificate of Need (CON) applications in response to the need identified in the *2020 State Medical Facilities Plan (SMFP)* for one additional Hospice Home Care Office in Rowan County. In accordance with N.C. Gen. Stat. §131E-185(a1)(1), this document includes comments relating to the representations made by the other applicants, and a discussion about whether the material in their applications complies with the relevant review criteria, plans, and standards. Carolina Caring organized its discussion first with a summary of comparative factors the Agency typically considers, and then by reviewing each competing application according to the general CON statutory review criteria. These comments illustrate why the application submitted by Carolina Caring, Inc. (Carolina Caring) represents the most effective alternative for development of a new hospice home care program in Rowan County.

These comments discuss the multiple specific deficiencies in the competing applications that necessitate their denial, and combined with an overall comparison of the applications, Carolina Caring believes demonstrate the superiority of its proposed project versus all the other applicants. Carolina Caring was chartered by the State of North Carolina in 1979, and is one of North Carolina's original hospice providers. Because of its long history of providing hospice services in the western Piedmont of North Carolina, and its history of service to Rowan County residents, Carolina Caring has established a significant level of support and coordination with other healthcare providers in Rowan County. On pages 77-81 of its application, and in the many letters of support included in Exhibit L.5, Carolina Caring summarizes its extensive outreach efforts and engagement with the local healthcare provider community and with Rowan County residents, including during 2020, two educational Caregiver Conferences and a workshop for Rowan County EMS personnel. Carolina Caring is committed to Rowan County, and such a demonstration of dedication is a critical leading indicator of which applicant represents the most effective alternative for Rowan County residents.

The Agency typically performs a comparative analysis when evaluating applications in a competitive batch review. The purpose is to identify which proposal would bring the greatest overall benefit to the community. The table on the following page summarizes objective metrics for this review, based on comparative factors the Agency applied in the 2018 Cumberland County hospice batch review, which is the most recent hospice home care office Agency Finding.

2020 Rowan County Hospice Batch Review - Comparative Analysis

Applicant	Carolina Caring	Bayada Hospice	Amedisys Hospice	Hospice & Palliative Care of Rowan County	Adoration Home Health & Hospice	PruittHealth Hospice	Continuum Care of North Carolina	Personal Home Care of NC
Conforming to Statutory Review Criteria	**Yes**	No	No	No	No	No	No	No
Not for Profit/For Profit	**NFP**	NFP	FP	NFP	FP	FP	FP	FP
Geography/Office Location	**China Grove**	Salisbury	Salisbury	Salisbury	Salisbury	Salisbury	Salisbury	Salisbury
Unduplicated Admissions - PY3	**224**	241	273	238	263	308	194	227
Days of Care - PY3	**16,092**	18,830	20,341	18,564	16,473	23,100	15,074	18,464
Average Length of Stay (ALOS), PY3	**71.8**	78.1	74.5	78.0	62.6	75.0	77.7	81.3
Rowan Patient Origin - PY3	**96.4%**	87.10%	82.40%	100.00%	57.00%	55.30%	95.90%	84.10%
Physician Support Letters	**5**	3	0	26	2	0	4	1
Provider Support Letters	**38**	0	12	5	2	0	17	11
Clergy/Community Support Letters	**32**	0	3	12	2	0	4	11
RN Salary - PY3	**$78,797**	$84,272	$77,690	$69,201	$67,626	$81,481	$79,070	$79,560
CNA Salary - PY3	**$31,818**	$36,414	$29,331	$32,470	$32,460	$34,503	$36,414	$30,600
SW Salary - PY3	**$56,531**	$67,626	$62,249	$57,682	$60,593	$64,437	$62,757	$58,140
Charity Care % of Gross Revenue - PY3	**1.64%**	1.11%	0.00%	1.88%	2.72%	1.51%	2.75%	1.00%
Medicare % of Days of Care - PY3	**89.80%**	90.00%	91.30%	94.00%	93.10%	96.40%	88.00%	89.40%
Medicaid % of Days of Care - PY3	**4.70%**	6.15%	5.00%	1.00%	2.00%	1.00%	7.00%	4.90%
Net Revenue/Unduplicated Admission - PY3	**$15,215**	$14,389	$12,702	$14,917	$10,942	$14,339	$14,919	$17,715
Net Revenue/Day of Care - PY3	**$211.79**	$184.16	$170.48	$191.25	$174.70	$191.19	$192.00	$217.80
Operating Expense/Unduplicated Admission - PY3	**$11,277**	$11,657	$10,593	$13,624	$8,046	$11,249	$13,635	$16,326
Operating Expense/Day of Care - PY3	**$156.97**	$149.20	$142.17	$174.66	$128.46	$149.98	$175.47	$200.71
Taxes & Benefits % - PY3	**19%**	25%	18%	27%	20%	24%	22%	21%
Average Case Load								
RN	**12**	10	13	12.5	12	12	10	9
SW	**35**	25	45	28.94	31	30	25	24
NA	**10**	8	11	9.5	13	10	8	10
Chaplain	**50**	35	55	57.5	51	40	25	35
Volunteer	**2**	4	45	49	18	2	50	1

2020 Rowan County Hospice Batch Review - Comparative Analysis Rankings

Applicant	Carolina Caring	Bayada Hospice	Amedisys Hospice	Hospice & Palliative Care of Rowan County	Adoration Home Health & Hospice	PruittHealth Hospice	Continuum Care of North Carolina	Personal Home Care of NC
Conformity to Statutory Review Criteria	**1**	8	8	8	8	8	8	8
Not for Profit/For Profit	**1**	1	4	1	4	4	4	4
Office Location	**1**	4	4	4	4	4	4	4
Unduplicated Admissions - PY3	**6**	4	2	5	3	1	8	7
Days of Care - PY3	**7**	3	2	4	6	1	8	5
Average Length of Stay (ALOS), PY3	**2**	7	3	6	1	4	5	8
Rowan Patient Origin - PY3	**2**	4	6	1	7	8	3	5
Physician Support Letters	**2**	4	8	1	5	8	3	6
Provider Support Letters	**1**	8	3	5	6	8	2	4
Clergy/Community Support Letters	**1**	8	5	2	6	8	4	3
Key Direct Care Staff Salaries	**8**	1	5	5	5	2	3	4
Charity Care % of Gross Revenue - PY3	**4**	6	8	3	2	5	1	7
Medicare % of Days of Care - PY3	**6**	5	4	2	3	1	8	7
Medicaid % of Days of Care - PY3	**5**	2	3	7	6	7	1	4
Net Revenue/Unduplicated Admission - PY3	**7**	4	2	5	1	3	6	8
Net Revenue/Day of Care - PY3	**7**	3	1	5	2	4	6	8
Operating Expense/Unduplicated Admission - PY3	**4**	5	2	6	1	3	7	8
Operating Expense/Day of Care - PY3	**5**	3	2	6	1	4	7	8
Taxes & Benefits % - PY3	**7**	2	8	1	6	3	4	5
Ancillary & Support Services	**1**	1	6	1	6	6	1	1
Average Case Load	**5**	2	8	6	6	4	3	1
Total Value	**83**	**85**	**94**	**84**	**89**	**96**	**96**	**115**
Conclusion	**Most Effective**	**Not Approvable**	**Not Approvable**	**Not Approvable**	**Not Approvable**	**Not Approvable**	**Not Approvable**	**Not Approvable**

The second of the preceding tables provides a ranking of the results of the comparative analysis from the first table, showing that Carolina Caring's application, with the lowest cumulative score, ranks as the most effective alternative. In addition, each of the competing applications is non-conforming to the CON statutory review criteria, and is thus not approvable. Therefore, Carolina Caring is both the most effective alternative in the head-to-head comparison and the only approvable application. Of specific note:

- Carolina Caring is one of only three not-for-profit applicants, and will have a positive impact on access to hospice services for all in need. As healthcare spending on hospice services has increased since 2000, the number of for profit hospice agencies has skyrocketed from 30% in 2000 to now representing 70% of all hospice agencies in the United States[1]. Even though not-for-profit and for-profit hospices are paid the same, for-profit corporations use tactics to reduce costs and generate more profit for shareholders or owners. Many such for-profit providers appear to be "profiteering" by leveraging the Medicare Hospice Benefit to make hospice a business model and generate unfair profits by putting financial goals ahead of quality care for the terminally ill. See Attachment 1 for the recent study "Profiteering" by the National Hospice Cooperative which highlights the striking and consistent gap between for-profit and not-for-profit providers. By contrast, as a mission-focused organization, a not-for-profit provider such as Carolina Caring typically spends more on comprehensive care per patient, provides more care in home settings, readmits for hospital care at lower frequency than for profits, and discharges patients before dying at a lower percentage.
- Carolina Caring projects the second highest Rowan County patient origin percentage, again reflecting Carolina Caring's not-for-profit commitment to serving Rowan County residents, and, unlike many of the for-profit competing applicants, not leveraging the Rowan County need determination as a vehicle for accessing residents of a larger and more profitable multi-county service area.
- Carolina Caring has a strong and documented history of providing high quality of care. As stated in Carolina Caring's application, the Centers for Medicare and Medicaid Services (CMS) created the Hospice Compare website to publicly share quality data for hospice providers. Carolina Caring is included in the report, which CMS recently updated with data collected between June 1, 2019 and May 31, 2020. Carolina Caring's scores continue to rise, scoring better than the average score of all hospice providers nationwide in each of the seven quality measures. Carolina Caring compares favorably with the competing applicants, as shown in the following table.

[1] http://medpac.gov/docs/default-source/data-book/july2020_databook_entirereport_sec.pdf?sfvrsn=0, page 190.

Most Recent CMS Hospice Compare Scores

	FAMILY EXPERIENCE OF CARE							
Applicant	**Comm w/ Family**	**Timely Help**	**Treat Pt w/Respect**	**Emotional/ Spiritual Support**	**Help - Pain & Symptoms**	**Training fam to care for pt.**	**Rating**	**Willing to Recommend**
Carolina Caring (10/17 - 9/19)	**83%**	**84%**	**93%**	**90%**	**78%**	**77%**	**85%**	**90%**
Carolina Caring (6/19 - 5/20)	**86.5%**	**84.9%**	**96.4%**	**94.1%**	**85.7%**	**80.7%**	**92.0%**	**93.3%**
Bayada	82.4%	76.8%	91.8%	90.8%	74.6%	77.4%	81.4%	83.6%
Amedisys	78.3%	73.7%	89.7%	88.7%	74.3%	75.0%	78.0%	81.0%
Hospice of Iredell	86%	88%	94%	95%	81%	79%	90%	95%
Adoration	77.5%	72%	86%	88.5%	74%	75%	77%	80%
PruittHealth	81.5%	80.5%	91.5%	89.5%	76%	79.5%	80%	80.5%
Continuum Care	77%	69.5%	88.5%	87.5%	70.5%	78.0%	75.5%	84.5%
PHC Hospice	no hospice experience							

Source: CMS

- Carolina Caring projected utilization based upon a reasonable and conservative methodology, using supported assumptions associated with the Rowan County marketplace. Most of the competing applicants created unrealistic utilization projections with unreasonable patient average length of stay and patient days of care, seemingly designed to portray more favorable comparable statistics for the Agency review.
- Carolina Caring projects a combined Medicare, Medicaid and self-pay/charity care payor mix of 96%, which is a slightly higher percentage of medically underserved patients than is currently served on average by Rowan County hospice home care agencies. This realistic and supported projection is indicative of Carolina Caring's commitment to serving the medically needy and indigent with quality healthcare services. This philosophy is also consistent with the Access Basic Principle described in the 2020 State Medical Facilities Plan.
- Carolina Caring is the only applicant proposing to develop its hospice office in China Grove. All the other applicants propose to locate their office in Salisbury, which is already host to the only two Rowan County-based hospice home care agencies. Specifically, the City of Kannapolis, which spans Rowan and Cabarrus counties, is more populous than Salisbury (Salisbury's population - 34,959 vs. Kannapolis' population - 49,324 according the 2019 estimate of the North Carolina Office of State Budget & Management). To best connect with residents from throughout Rowan County, a central Rowan County location such as China Grove is more advantageous in providing

education, support, and access to care. Carolina Caring thus represents the most effective alternative from a geographic access/location of office perspective.

- Carolina Caring will provide a full continuum of hospice services to Rowan County residents, including specialized services for particular populations in need of hospice services, such as veterans, African-Americans, and pediatric patients. In fact, of the seven competing applicants, only two mentioned care for pediatric patients.
- Several of the applicants projected unreasonably high staff salaries, without providing any basis for the assumptions. By contrast, Carolina Caring projected realistic staff salaries based on its actual experience as an employer, and a review of salaries in the Rowan County labor market. Further, as stated in its application, Carolina Caring is recognized as one of Modern Healthcare's Best Places to Work in Healthcare. In fact, for the second consecutive year, Carolina Caring has been so recognized by Modern Healthcare, which recently announced that Carolina Caring is on its 2020 Best Places to Work list. Carolina Caring is ranked fifth on the list, and is the highest ranking hospice in the United States in 2020, and the highest ranking hospice in North Carolina in both 2019 and 2020.
- Carolina Caring has thoroughly demonstrated its engagement with and commitment to the Rowan County community. The application describes at length the substantial efforts Carolina Caring has made to educate Rowan citizens regarding hospice and palliative care, and in coordinating care with the local provider organizations. The healthcare provider and community letters of support included in Carolina Caring's application are evidence of this critical established foundation which Carolina Caring has already laid.

The Carolina Caring application conforms to all CON Review Criteria and best achieves the Basic Principles of the 2020 SMFP (Policy GEN-3). The competing applications are not conforming to all the CON Review Criteria. In particular, most of the competing applicants should not be approved because the applicants were unrealistically aggressive in projecting admissions, average length of stay and/or days of care. They include in their applications unsupported utilization projections designed to maximize days of care and thus make their applications appear more attractive in the Agency comparative analysis. Common among six of the seven competing applications was an unjustifiably high average length of stay projection. Longer lengths of stay can draw the attention of regulators such as the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services Office of the Inspector General. Longer lengths of stay are also associated with higher profitability among hospice organizations, according to a report[2] by the Medicare Payment Advisory Commission (MEDPAC). Not surprisingly, for-profit hospices tended to see the most significant margin increases due to length of stay. And, as stated in MedPac's July 2020 Healthcare spending

[2] http://medpac.gov/docs/default-source/data-book/july2020_databook_entirereport_sec.pdf?sfvrsn=0

report: *"for-profit hospices have longer average lengths of stay than non-profit hospices."*[3] Most of the applicants also unrealistically inflated their projections regarding Medicare and/or Medicaid access to hospice services in Rowan County. In summary, Carolina Caring represents the only approvable application, and is the most effective alternative for development of the need-determined hospice home care office in Rowan County.

[3] Ibid, page 193.

Specific Comments Regarding the Competing Applications

Bayada Hospice (Bayada) Project ID # F-11943-20

Bayada does not provide hospice services in North Carolina. Bayada's lack of North Carolina hospice infrastructure means that it would have to build from scratch an interdisciplinary hospice care team, which will likely lead to lost time in establishing a fully functioning hospice program. Further, Bayada references its home health office in Rowan County, yet surprisingly, despite this local office, Bayada's application included no discussion of any prior substantive community involvement, or little to no establishment of community education events for local residents or collaborative relationships with provider community. The application included only three letters of support for its project.

Bayada's application should not be approved as proposed. Carolina Caring identified the following specific issues, each of which contributes to the application's non-conformity to statutory review criteria.

Comments Specific to Criterion 1

- Bayada does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. See discussion regarding Criterion 3. Therefore, Bayada does not adequately demonstrate that its proposal would maximize healthcare value. Consequently, the application is not consistent with Policy GEN-3 and is not conforming to Criterion 1.

Comments Specific to Criterion 3

- Bayada's application should not be approved as proposed, because the applicant projected unsupported utilization projections and unreasonable projection of days of care. In Section Q (page 100), Bayada projects that in Project Year 3 it will hold 24% market share in Rowan County. Bayada justifies this market share projection with a claim that it has *"well documented referral relationships",* and *"extensive corporate resources for marketing, community outreach and education".* However, Bayada has provided no actual evidence of either relationships or community outreach; its application included only three letters of support. Therefore, the market share projection is not supported.

- Bayada's projection of average length of stay (ALOS) is 78.1 days, which is unreasonably high and the second highest of all the applications. On page 84 of its application, the applicant indicates this is based on *"Bayada experience in New Jersey and Pennsylvania."* This is a fatal flaw; Bayada did not document how its ALOS

experience in other states is in any way relevant and applicable to Rowan County. This unrealistic ALOS projection is apparently designed to increase the projected days of care and portray more favorable comparable statistics for the Agency review. Therefore, Bayada's ALOS projection is not supported.

- Bayada's application includes a discrepancy regarding the projection of continuous care hours and days, as the projections in the Form C assumptions on page 102 do not match the projections in Form C on page 104.

- In summary, the product of the unsupported market share projection and the high projected ALOS results in an unreasonably high projection of hospice days of care. Bayada does not adequately demonstrate the need the projected population has for the proposed hospice agency. Consequently, the application is not conforming to Criterion 3, and its application is not approvable.

Comments Specific to Criterion 4

- The Bayada application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. A project that cannot be approved cannot be an effective alternative. Consequently, Bayada's application is not conforming to this criterion.

Comments Specific to Criterion 5

- The Bayada application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. Specifically, Bayada manufactured an unreasonably high and unsupported projection of hospice days of care, which results in an unwarranted projection of costs and charges. Further, Bayada used the artificially high projection of days of care apparently to appear to be more appealing with regard to a comparison of net revenue and operating expenses per day of care. A project that does not adequately demonstrate need cannot demonstrate financial feasibility. Consequently, the application is not conforming to this criterion.

- Bayada projects unreasonably high staff salaries for a Rowan County-based hospice agency. Bayada's application provided no information at all regarding the basis of its salary projections. The assumption therefore must be that Bayada used artificially high salary projections for RNs, CNAs, and Social Workers apparently to appear to be more appealing in the Agency comparative analysis.

- Bayada projects 25% benefits and taxes percentage of salaries for its staff. This is an unreasonably high figure for a hospice agency. Bayada did not justify the basis of this projection, and thus did not base its financial projections upon reasonable projections of costs.

Comments Specific to Criterion 6

- Bayada did not adequately demonstrate that its projected utilization is reasonable, credible or adequately supported. Therefore, Bayada did not adequately demonstrate in its application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies. See Criterion 3 for additional discussion. Consequently, the Bayada application did not demonstrate that its proposed project will not result in unnecessary duplication of existing health services, and thus is not conforming to Criterion 6.

Comments Specific to Criterion 13

- Bayada did not reasonably project the extent to which the elderly and medically underserved groups expect to utilize the proposed services. Specifically, Bayada projects an unjustifiably high Medicaid payor mix of 6.15%. On page 84 of its application, Bayada states that *"payor percentages are based on Bayada's review of North Carolina Hospice LRA Data Supplements and Bayada's experience in other states."* However, Bayada does not explain the breadth of its review of North Carolina LRA data and how overall North Carolina payor mix information would be applicable specifically to Rowan County, especially given that local payor mix data is available. Particularly damaging, Bayada provides no evidence or explanation regarding how its experience in other states is at all applicable to the projected Rowan County payor mix. The Bayada application is therefore not conforming to Criterion 13.

Comments Specific to Criterion 18a

- Bayada did not adequately demonstrate the effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost-effectiveness and access to services proposed. Bayada did not adequately demonstrate that projected utilization is reasonable, credible or adequately supported. The applicant did not adequately demonstrate financial

feasibility based upon a reasonable projection of costs and charges. Bayada did not adequately demonstrate in its application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies, and did not demonstrate that its proposal is the most effective alternative. Also, Bayada did not reasonably project the extent to which the elderly and medically underserved groups expect to utilize the proposed services. See Criteria 3, 4, 5, 6 and 13 for additional discussion. Consequently, the Bayada application is not conforming to Criterion 18a.

Amedisys Hospice (Amedisys) Project ID # F-11945-20

This SMFP need determination merely represents a business investment opportunity for this out-of-state for-profit business venture. Amedisys is a prime example of the hospice "profiteering" referred to earlier in these written competitive comments. In fact, as shown in Attachment 2, during a 2019 presentation, Amedisys CEO Paul Kusserow said *"We are really going to feed the beast in hospice. Right now from an M&A perspective, from where should we be focusing on de novos, on tuck-ins, on deals, on integrations—we are pushing hospice".* The CEO followed that up just this week, saying the company focus is *"on continuing to steal market share in facilities."* Amedisys has been doubling down on hospice as the company braces for disruption to its home health care business profitability stemming from the transition to the Patient Driven Grouping Models. These CEO quotes clearly highlights that the primary focus of Amedisys leadership for this CON application is profit opportunity, and not clinical service to Rowan County terminally ill patients and their families. As further evidence of this, see Attachment 3 for a press release from the United States Department of Justice announcing that Amedisys agreed to pay $150 million to the Federal government to resolve allegations that Amedisys violated the False Claims Act by submitting false billings to the Medicare program.

The Amedisys application should not be approved as proposed. Carolina Caring identified the following specific issues, each of which contributes to the application's non-conformity to statutory review criteria.

Comments Specific to Criterion 1

- Amedisys does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. See discussion regarding Criterion 3. Therefore, Amedisys does not adequately demonstrate that its proposal would maximize healthcare value. Consequently, the application is not consistent with Policy GEN-3 and is not conforming to Criterion 1.

Comments Specific to Criterion 3

- Amedisys' application should not be approved as proposed, because the applicant projected unsupported utilization projections and an extremely high and unreasonable projection of days of care. In Section C (page 57), Amedisys projects that in Project Year 3 it will hold 27.6% market share in Rowan County. Amedisys justifies this market share projection with a claim that it *"reflects the need to ramp up a new hospice office to address the decline in utilization and increasing death rates."* Amedisys provides no further justification for the market share projection; this one sentence does not represent a rationale. In fact, Amedisys' application includes a dearth of indications of local support

for the project, including no letters from physicians. Therefore, the market share projection is not supported.

- The Amedisys projection of average length of stay (ALOS) is 74.5 days, which is unreasonably high. Nowhere in the application did Amedisys explain the basis for its ALOS assumption, which is a fatal flaw. This unrealistic ALOS projection is apparently designed to increase the projected days of care and portray more favorable comparable statistics for the Agency review. Therefore, Amedisys' ALOS projection is not supported.

- In addition, Amedisys projects to serve residents of Cabarrus, Davidson, Davie and Iredell counties at the proposed Rowan County hospice office. Amedisys projects that nearly 18% of its Rowan agency patients will be residents of these other counties. This is not reasonable because each of those counties currently has a surplus of hospice home patients, as shown in Table 13B of the 2020 SMFP. Patients in those counties are already well served by their local hospice providers and are most unlikely to need to obtain hospice services from a Rowan County agency.

- In summary, the product of the unsupported market share projection, the high projected ALOS, and substantial numbers of patients from other counties, results in an unreasonably high projection of hospice days of care. Amedisys does not adequately demonstrate the need the projected population has for the proposed hospice agency. Consequently, the application is not conforming to Criterion 3.

Comments Specific to Criterion 4

- The Amedisys application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. A project that cannot be approved cannot be an effective alternative. Consequently, Amedisys' application is not conforming to this criterion.

- Throughout its application, beginning in Section B and continuing in Sections C and N, Amedisys refers to the proposed Rowan County office as a branch of its Pembroke office in Robeson County. Pembroke is located in eastern North Carolina, 120 miles away from Salisbury, or 2 hours and 25 minute drive time. Amedisys references *"cost-saving efficiencies by leveraging its existing administrative and support services already in place"* (p. 30 Amedisys application). It is not clear that Amedisys proposes for the Rowan County "satellite" office to be a full-service office, rather than just a secondary office to Pembroke. The term Satellite office is not recognized in the hospice

regulations. In fact, according to Medicare, *"Multiple location means a Medicare-approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice issued the certification number. A multiple location must meet all of the conditions of participation applicable to hospices."* It is concerning that Amedisys uses the term "Satellite", which seems to indicate Amedisys does not intend to meet the requirement of a separately approved Medicare location offering a comprehensive list of services. Thus, Amedisys did not demonstrate that its proposal is the most effective alternative.

Comments Specific to Criterion 5

- The Amedisys application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. Specifically, Amedisys manufactured an unreasonably high and unsupported projection of hospice days of care, which results in an unwarranted projection of costs and charges. Further, Amedisys used the artificially high projection of days of care apparently to appear to be more appealing with regard to a comparison of net revenue and operating expenses per day of care. A project that does not adequately demonstrate need cannot demonstrate financial feasibility. Consequently, the application is not conforming to this criterion.

Comments Specific to Criterion 6

- Amedisys did not adequately demonstrate that its projected utilization is reasonable, credible or adequately supported. Therefore, Amedisys did not adequately demonstrate in its application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies. See Criterion 3 for additional discussion. Consequently, the Amedisys application did not demonstrate that its proposed project will not result in unnecessary duplication of existing health services, and thus is not conforming to Criterion 6.

Comments Specific to Criterion 8

- Amedisys did not demonstrate it adequately provides for necessary ancillary and support services. Specifically, Amedisys has no commitments or even expressed interest from any facility for establishing contractual agreements for the provision of inpatient and respite care, and thus has not demonstrated any support or interest from any hospital or

skilled nursing facility to provide this level of care. As such, Amedisys does not demonstrate that it will provide reasonably accessible availability of inpatient and respite care for the patients of its proposed Rowan County agency. The Amedisys application is therefore not conforming to Criterion 8.

Comments Specific to Criterion 13

- Amedisys did not reasonably project the extent to which the elderly and medically underserved groups expect to utilize the proposed services. Specifically, Amedisys projects an unjustifiably high Medicare payor mix of 91.3%. Amedisys also projects 5% Medicaid payor mix with no justification. On page 95 of its application, Amedisys states *"using the historic experience of its Garner location, the Applicant has established its projected payor sources for the third full fiscal year of operation."* However, Amedisys provides no evidence or explanation regarding how its Wake County payor mix is specifically applicable to Rowan County. The Amedisys application is therefore not conforming to Criterion 13.

Comments Specific to Criterion 18a

- Amedisys did not adequately demonstrate the effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost-effectiveness and access to services proposed. Amedisys did not adequately demonstrate that projected utilization is reasonable, credible or adequately supported. Amedisys did not adequately demonstrate in its application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies, and did not demonstrate that its proposal is the most effective alternative. The applicant did not adequately demonstrate financial feasibility based upon a reasonable projection of costs and charges. Amedisys did not demonstrate it adequately provides for necessary ancillary and support services. Also, Amedisys did not reasonably project the extent to which the elderly and medically underserved groups expect to utilize the proposed services. See Criteria 3, 4, 5, 6, 8, and 13 for additional discussion. Consequently, the Amedisys application is not conforming to Criterion 18a.

Hospice of Iredell County (Iredell) Project ID # F-11948-20

Iredell's application included no discussion of any prior substantive community involvement, or little to no establishment of community education events for Rowan County residents or collaborative relationships with the Rowan County provider community. For example, the application says Iredell "will hold community education events and outreach", and claims it will offer veterans, children's programs, grief counseling, etc. Yet prior to its CON application Iredell made no effort to have any community education in Rowan despite its adjacent proximity.

Iredell's application should not be approved as proposed. Carolina Caring identified the following specific issues, each of which contributes to the application's non-conformity to statutory review criteria.

Comments Specific to Criterion 1

- Iredell does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. See discussion regarding Criterion 3. Therefore, Iredell does not adequately demonstrate that its proposal would maximize healthcare value. Consequently, the application is not consistent with Policy GEN-3 and is not conforming to Criterion 1.

Comments Specific to Criterion 3

- Iredell's application should not be approved as proposed, because the applicant projected unsupported utilization projections and unreasonable projection of days of care. The Iredell application is notable for the complete lack of detail in documenting its utilization projections and assumptions. Section C.3 regarding the demonstration of need, for example, consists of just one page of narrative. The Form C Utilization in Section Q similarly provides just six bullet point assumptions for the projected admissions, patients served, deaths and days of care. Iredell completely fails to back up its projections with any data or explanation by which the Agency could evaluate the reasonableness of the projections. Therefore, the utilization projection is not supported and not approvable.

- Iredell's projection of average length of stay (ALOS) is 78 days, which is unreasonably high. Similar to its projection of utilization described above, Iredell did not document its ALOS projection: the application simply includes the brief statement *"ALOS at 78 days"* on Form C Utilization. This ALOS projection is both unrealistic and unjustified, apparently designed to increase the projected days of care and portray more favorable

comparable statistics for the Agency review. Therefore, Iredell's ALOS projection is not supported.

- In summary, the product of the unsupported utilization projection and the high projected ALOS results in an unreasonably high and unjustified projection of hospice days of care. Iredell does not adequately demonstrate the need the projected population has for the proposed hospice agency. Consequently, the application is not conforming to Criterion 3.

Comments Specific to Criterion 4

- The Iredell application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. A project that cannot be approved cannot be an effective alternative. Consequently, Iredell's application is not conforming to this criterion.

Comments Specific to Criterion 5

- The Iredell application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. Specifically, Iredell manufactured an unreasonably high and unsupported projection of hospice days of care, which results in an unwarranted projection of costs and charges. Further, Iredell used the artificially high projection of days of care apparently to appear to be more appealing with regard to a comparison of net revenue and operating expenses per day of care. A project that does not adequately demonstrate need cannot demonstrate financial feasibility. Consequently, the application is not conforming to this criterion.

- Iredell projects 27% benefits and taxes percentage of salaries for its staff, by far the highest of any applicant. However, this is an unreasonably high figure for a hospice agency. Iredell did not justify the basis of this projection, and thus did not base its financial projections upon reasonable projections of costs.

Comments Specific to Criterion 6

- Iredell did not adequately demonstrate that its projected utilization is reasonable, credible or adequately supported. Therefore, Iredell did not adequately demonstrate in its application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies. See Criterion 3 for additional discussion.

Consequently, the Iredell application did not demonstrate that its proposed project will not result in unnecessary duplication of existing health services, and thus is not conforming to Criterion 6.

Comments Specific to Criterion 13

- Iredell did not reasonably project the extent to which the elderly and medically underserved groups expect to utilize the proposed services. Specifically, Iredell projects an unjustifiably high Medicare payor mix of 94%, and also a low Medicaid payor mix of 1%. Nowhere in its application (not in Section C, Section L, or Section Q), does Iredell provide any narrative or information or basis for its payor mix assumptions. This is a fatal flaw. The most reasonable basis upon which to develop the patient origin projection is the historical patient origin of the two Rowan County-based agencies, as shown on the payor mix summary table below. This table shows the unreasonableness of Iredell's high Medicare payor mix assumption, as well as the inadequacy of its low Medicaid payor mix assumption, and the Iredell application is therefore not conforming to Criterion 13.

FY2019 Payor Mix by Days of Care
Rowan County-based Hospice Home Care Agencies

Payment Source	Trellis Supportive Care Rowan (HOS2425)	Novant Health Hospice (HOS4599)	Combined Total	Combined %
Medicare	19,569	9,790	29,359	89.8%
Medicaid	1,016	368	1,384	4.2%
Private Insurance	1,180	549	1,729	5.3%
Self-Pay	35	156	191	0.6%
Other	-	30	30	0.1%
Total	**21,800**	**10,893**	**32,693**	**100.0%**

Source: Page 3, 2020 Hospice Data Supplements

Comments Specific to Criterion 18a

- Iredell did not adequately demonstrate the effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost-effectiveness and access to services proposed. Iredell did not adequately demonstrate that projected utilization is reasonable, credible or adequately

supported. Iredell did not adequately demonstrate in its application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies, and did not demonstrate that its proposal is the most effective alternative. The applicant did not adequately demonstrate financial feasibility based upon a reasonable projection of costs and charges. Also, Iredell did not reasonably project the extent to which the elderly and medically underserved groups expect to utilize the proposed services. See Criteria 3, 4, 5, 6 and 13 for additional discussion. Consequently, the Iredell application is not conforming to Criterion 18a.

Adoration Home Health & Hospice (Adoration) Project ID # F-11949-20

Adoration, as a subsidiary of a global investment firm, has no history of offering healthcare services in North Carolina. This SMFP need determination simply represents a business investment opportunity for this out-of-state for-profit corporation.

Adoration's lack of North Carolina infrastructure would mean that it would have to build from scratch an entire interdisciplinary hospice care team, as well as start from the ground up to begin to establish relationships with the local residents and provider community. All of this will likely lead to lost time in establishing a fully functioning hospice program.

Adoration's application should not be approved as proposed. Carolina Caring identified the following specific issues, each of which contributes to the application's non-conformity to statutory review criteria.

Comments Specific to Criterion 1

- Adoration does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. See discussion regarding Criterion 3. Therefore, Adoration does not adequately demonstrate that its proposal would maximize healthcare value. Consequently, the application is not consistent with Policy GEN-3 and is not conforming to Criterion 1.

Comments Specific to Criterion 3

- Adoration's application should not be approved as proposed, because the applicant projected unsupported utilization projections and unreasonable projection of days of care. Specifically, Adoration projects that 43% of its patients at the Rowan County agency will be Stanly County residents. This projection defies logic because 1) the need determination is for a new agency that must be located in Rowan County (Adoration proposes a Salisbury office location) and 2) the Stanly County population is less than half that of Rowan County. As it stands, Adoration's application projects just 9,390 days of care for Rowan County residents (16,473 x 57%), which is by far the lowest total of any applicant.

- Adoration does not support its projections with documentation of support from the community; the application includes just six letters of support, and only two from Rowan County (the local community college and an EMS training employee). Therefore, the utilization projection is not supported.

- In summary, Adoration does not adequately demonstrate the need the projected population has for the proposed hospice agency. Consequently, the application is not conforming to Criterion 3.

Comments Specific to Criterion 4

- The Adoration application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. A project that cannot be approved cannot be an effective alternative. Consequently, Adoration's application is not conforming to this criterion.

Comments Specific to Criterion 5

- The Adoration application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. A project that does not adequately demonstrate need cannot demonstrate financial feasibility. Consequently, the application is not conforming to this criterion.

Comments Specific to Criterion 6

- Adoration did not adequately demonstrate that its projected utilization is reasonable, credible or adequately supported. Therefore, Adoration did not adequately demonstrate in its application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies. See Criterion 3 for additional discussion. Consequently, the Adoration application did not demonstrate that its proposed project will not result in unnecessary duplication of existing health services, and thus is not conforming to Criterion 6.

Comments Specific to Criterion 8

- Adoration did not demonstrate it adequately provides for necessary ancillary and support services. Specifically, Adoration has no commitments or even expressed interest from any facility for establishing contractual agreements for the provision of inpatient and respite care, and thus has not demonstrated any support or interest from any hospital or skilled nursing facility to provide this level of care. As such, Adoration does not demonstrate that it will provide reasonably accessible availability of inpatient and respite

care for the patients of its proposed Rowan County agency. The Adoration application is therefore not conforming to Criterion 8.

Comments Specific to Criterion 13

- Adoration did not reasonably project the extent to which the elderly and medically underserved groups expect to utilize the proposed services. Specifically, Adoration projects an unjustifiably high Medicare payor mix of 93.1%, and also a low Medicaid payor mix of 2%. On page 71 of its application, Adoration states that the projected payor mix *"is based upon a combination of: (1) the payor mix for hospices in Rowan County; (2) Adoration's agreements in place with existing hospitals and commitment to the provision of a target level of charity care to patients within Rowan County; and, (3) Adoration's experience in developing and operating similar facilities."* However, Adoration does not include in its application any information regarding agreements with existing hospitals, nor its purported commitment to the provision of a target level of charity care. Also, Adoration fails to explain how its experience at other unnamed facilities in other states is relevant or specifically applicable to the payor mix projection for Rowan County. Most significantly, the payor mix for hospices serving Rowan County do not support the Adoration projections. Most of the agencies that serve Rowan County residents are not based in Rowan County and serve relatively few Rowan County residents. Therefore, the more reasonable basis upon which to develop the patient origin projection is the historical patient origin of the two Rowan County-based agencies, which do primarily serve Rowan residents, as shown on the payor mix summary table below.

FY2019 Payor Mix by Days of Care
Rowan County-based Hospice Home Care Agencies

Payment Source	Trellis Supportive Care Rowan (HOS2425)	Novant Health Hospice (HOS4599)	Combined Total	Combined %
Medicare	19,569	9,790	29,359	89.8%
Medicaid	1,016	368	1,384	4.2%
Private Insurance	1,180	549	1,729	5.3%
Self-Pay	35	156	191	0.6%
Other	-	30	30	0.1%
Total	**21,800**	**10,893**	**32,693**	**100.0%**

Source: Page 3, 2020 Hospice Data Supplements

As is apparent, the historical Medicare payor mix for Rowan County does not support Adoration's high Medicare projection. And not surprisingly for a for-profit subsidiary of a global investment firm, Adoration proposes to minimize access to care for Medicaid recipients, with just 2% payor mix, which is inadequate for the Rowan County service area. The Adoration application is therefore not conforming to Criterion 13.

Comments Specific to Criterion 18a

- Adoration did not adequately demonstrate the effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost-effectiveness and access to services proposed. Adoration did not adequately demonstrate that projected utilization is reasonable, credible or adequately supported. Adoration did not adequately demonstrate in its application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies, and did not demonstrate that its proposal is the most effective alternative. The applicant did not adequately demonstrate financial feasibility based upon a reasonable projection of costs and charges. Adoration did not demonstrate it adequately provides for necessary ancillary and support services. Also, Adoration did not reasonably project the extent to which the elderly and medically underserved groups expect to utilize the proposed services. See Criteria 3, 4, 5, 6, 8 and 13 for additional discussion. Consequently, the Adoration application is not conforming to Criterion 18a.

PruittHealth Hospice (Pruitt) Project ID # F-11952-20

The PruittHealth application, among the entire batch review, is the application that appears to be most highly engineered for CON Agency review purposes, with unusually and unreasonably high utilization projections and operational statistics in the metrics the Agency has typically used in its comparative analysis. In fact, Pruitt projects by far the highest unduplicated admissions and patient days of care, as well as the highest Medicare payor percentage. At the same time, Pruitt demonstrated practically no effort to engage with the Rowan County community, and included no letters of support in its application.

Pruitt's application should not be approved. Carolina Caring identified the following specific issues, each of which contributes to the application's non-conformity to statutory review criteria.

Comments Specific to Criterion 1

- Pruitt does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. See discussion regarding Criterion 3. Therefore, Pruitt does not adequately demonstrate that its proposal would maximize healthcare value. Consequently, the application is not consistent with Policy GEN-3 and is not conforming to Criterion 1.

Comments Specific to Criterion 3

- Pruitt's application should not be approved as proposed, because the applicant projected unsupported utilization projections and unreasonable projection of days of care. In its Form C Utilization methodology in Section Q, Pruitt projects that in Project Year 3 it will hold 20.3% market share in Rowan County. Pruitt justifies this market share projection with a claim that it *"plans to immediately begin promoting community awareness and education about PruittHealth Hospice's services to increase hospice utilization."* However, Pruitt's application demonstrated practically no effort to engage with the Rowan County community, and included no letters of support at all. Therefore, the market share projection is not supported.

- Pruitt's projection of average length of stay (ALOS) is 75.0 days, which is unreasonably high. In its Form C Utilization methodology in Section Q, the applicant indicates this is based on its experience elsewhere (unnamed locations), and justified by the Trellis Supportive Care Rowan ALOS. However, Pruitt conveniently ignored the ALOS of the other Rowan County-based hospice agency, which is lower. Therefore, Pruitt's ALOS projection is not supported. This unrealistic ALOS projection is apparently designed to

increase the projected days of care and portray more favorable comparable statistics for the Agency review.

- In addition, as shown on page 37 of its application, Pruitt projects to serve residents of Cabarrus, Guilford, Forsyth, Union, and Mecklenburg counties at the proposed Rowan County hospice office. Pruitt projects that nearly 45% of its Rowan County agency patients will be residents of these other counties. This is not reasonable because each of those counties currently has a surplus of hospice home patients, as shown in Table 13B of the 2020 SMFP. Patients in those counties are already well served by their local hospice providers and are unlikely to need to obtain hospice services from a Rowan County agency. Clearly Pruitt is looking to leverage the Rowan County need determination as a vehicle for accessing residents of a larger and more profitable multi-county service area. This is made even more apparent when considering the nature of Pruitt's Wilkes County hospice agency, which Pruitt is strategically leveraging to serve a much broader catchment area than just Wilkes County (extending all the way south to Mecklenburg County), thus enhancing corporate profitability.

- In summary, the product of the unsupported market share projection and the high projected ALOS, and substantial numbers of patients from other counties, results in an unreasonably high projection of hospice days of care. Pruitt does not adequately demonstrate the need the projected population has for the proposed hospice agency. Consequently, the application is not conforming to Criterion 3.

Comments Specific to Criterion 4

- The Pruitt application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. A project that cannot be approved cannot be an effective alternative. Consequently, Pruitt's application is not conforming to this criterion.

Comments Specific to Criterion 5

- The Pruitt application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. Specifically, Pruitt manufactured an unreasonably high and unsupported projection of hospice days of care, which results in an unwarranted projection of costs and charges. Further, Pruitt used the artificially high projection of days of care apparently to appear to be more appealing with regard to a comparison of net revenue and operating expenses per day of care. A project

that does not adequately demonstrate need cannot demonstrate financial feasibility. Consequently, the application is not conforming to this criterion.

- Pruitt projects unreasonably high staff salaries for a Rowan County-based hospice agency. Pruitt's application did not provide any information regarding the basis of its salary projections. The assumption therefore must be that Pruitt is using artificially high salary projections for RNs, CNAs, NPs, and Social Workers apparently to appear to be more appealing in the Agency comparative analysis.

- Pruitt projects 24% benefits and taxes percentage of salaries for its staff. This is an unreasonably high figure for a hospice agency. Pruitt did not justify the basis of this projection, and thus did not base its financial projections upon reasonable projections of costs.

Comments Specific to Criterion 6

- Pruitt did not adequately demonstrate that its projected utilization is reasonable, credible or adequately supported. Therefore, Pruitt did not adequately demonstrate in its application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies. See Criterion 3 for additional discussion. Consequently, the Pruitt application did not demonstrate that its proposed project will not result in unnecessary duplication of existing health services, and thus is not conforming to Criterion 6.

Comments Specific to Criterion 8

- Pruitt did not demonstrate that it adequately provides for necessary ancillary and support services. Specifically, Pruitt has no commitments to or from, or even expressed interest from any facility for establishing contractual agreements for the provision of inpatient and respite care, and thus has not demonstrated any support or interest from any hospital or skilled nursing facility to provide this level of care. As such, Pruitt does not demonstrate that it will provide reasonably accessible availability of inpatient and respite care for the patients of its proposed Rowan County agency. The Pruitt application is therefore not conforming to Criterion 8.

Comments Specific to Criterion 13

- Pruitt did not reasonably project the extent to which the elderly and medically underserved groups expect to utilize the proposed services. Specifically, Pruitt projects an unjustifiably high Medicare payor mix of 96.4%, the highest of any applicant. On page 80 of its application, Pruitt states that *"PruittHealth Hospice used its historical experience and adjusted according to PruittHealth Hospice's desire to promote hospice home care services to the medically underserved and medically indigent."* However, this non-answer provides no justification for how Pruitt's projected Medicare payor mix is actually applicable to and realistic for Rowan County. By contrast, the most reasonable basis upon which to develop the patient origin projection is the historical patient origin of the two Rowan County-based agencies, as shown on the payor mix summary table below. This table shows that Pruitt's Medicare payor mix assumption is not reasonable, and the Pruitt application is therefore not conforming to Criterion 13.

FY2019 Payor Mix by Days of Care
Rowan County-based Hospice Home Care Agencies

Payment Source	Trellis Supportive Care Rowan (HOS2425)	Novant Health Hospice (HOS4599)	Combined Total	Combined %
Medicare	19,569	9,790	29,359	89.8%
Medicaid	1,016	368	1,384	4.2%
Private Insurance	1,180	549	1,729	5.3%
Self-Pay	35	156	191	0.6%
Other	-	30	30	0.1%
Total	**21,800**	**10,893**	**32,693**	**100.0%**

Source: Page 3, 2020 Hospice Data Supplements

- Further, and not surprisingly for a for-profit entity, Pruitt proposes to minimize access to care for Medicaid recipients, with just a 1% payor mix, the lowest Medicaid payor mix in the batch review, and inadequate for the Rowan County service area. The Pruitt application is not conforming to Criterion 13.

Comments Specific to Criterion 18a

- Pruitt did not adequately demonstrate the effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost-effectiveness and access to services proposed. Pruitt did not adequately demonstrate that projected utilization is reasonable, credible or adequately supported. Pruitt did not adequately demonstrate in its application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies, and did not demonstrate that its proposal is the most effective alternative. The applicant did not adequately demonstrate financial feasibility based upon a reasonable projection of costs and charges. Pruitt did not demonstrate it adequately provides for necessary ancillary and support services. Also, Pruitt did not reasonably project the extent to which the elderly and medically underserved groups expect to utilize the proposed services. See Criteria 3, 4, 5, 6, 8, and 13 for additional discussion. Consequently, the Pruitt application is not conforming to Criterion 18a.

Continuum Care of North Carolina (Continuum) Project ID # F-11955-20

Continuum has no history of offering healthcare services in North Carolina. Continuum's lack of North Carolina infrastructure would mean that it would have to build from scratch an entire interdisciplinary hospice care team, as well as start from the ground up to begin to establish relationships with the local residents and provider community. All of this will likely lead to lost time in establishing a fully functioning hospice program. Further, Continuum's application states, on page 16, that its hospice service will be overseen by a National Clinical Director. This seems to indicate that the proposed Rowan County agency will have either no or weak local clinical oversight, with remote direction from Brooklyn, New York.

This SMFP need determination merely represents a business investment opportunity for this out-of-state for-profit business venture. Continuum is an example of the hospice "profiteering" referred to earlier in these written competitive comments. As demonstrated by its 2017 adjusted need petition to the State Health Coordinating Council[4], Continuum's goal is actually to access the populous and lucrative Mecklenburg County marketplace; a prospective Rowan County hospice home care agency located just north of Mecklenburg County would make the perfect vicarious vehicle for such a business venture.

Continuum's application should not be approved as proposed. Carolina Caring identified the following specific issues, each of which contributes to the application's non-conformity to statutory review criteria.

Comments Specific to Criterion 1

- Continuum does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. See discussion regarding Criterion 3. Therefore, Continuum does not adequately demonstrate that its proposal would maximize healthcare value. Consequently, the application is not consistent with Policy GEN-3 and is not conforming to Criterion 1.

Comments Specific to Criterion 3

- Continuum's projection of average length of stay (ALOS) is 77.7 days, which is unreasonably high. On page 106 of its application, the applicant indicates this is based on *"the statewide median average length of stay per admission."* However, Continuum did not document how a statewide ALOS rate is specifically applicable to Rowan County.

[4] https://info.ncdhhs.gov/dhsr/mfp/pets/2017/ltbh/0728_hos_mecklenburg_petition.pdf

In fact, Continuum ignored the available local Rowan County ALOS data, which is lower. Therefore, Continuum's ALOS projection is not supported.

- In summary, the high projected ALOS results in an unreasonably high projection of hospice days of care for the projected number of Continuum patients. Continuum does not adequately demonstrate the need the projected population has for the proposed hospice agency. Consequently, the application is not conforming to Criterion 3.

Comments Specific to Criterion 4

- Continuum references it plan for accreditation by Community Health Accreditation Partner (CHAP). CHAP is not the highest standard of quality accreditation compared to The Joint Commission, which accredits Carolina Caring, and therefore is a less effective alternative.

- The Continuum application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. A project that cannot be approved cannot be an effective alternative. Consequently, Continuum's application is not conforming to this criterion.

Comments Specific to Criterion 5

- The Continuum application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. Specifically, Continuum manufactured an unsupported projection of hospice days of care, which results in an unwarranted projection of costs and charges. A project that does not adequately demonstrate need cannot demonstrate financial feasibility. Consequently, the application is not conforming to this criterion.

- Continuum projects unreasonably high staff salaries for a Rowan County-based hospice agency. Continuum's application did not provide any information regarding the basis of its salary projections. The assumption therefore must be that Continuum used artificially high salary projections for RNs, CNAs, NPs, and Social Workers apparently to appear to be more appealing in the Agency comparative analysis.

- Continuum projects 22% benefits and taxes percentage of salaries for its staff. This is an unreasonably high figure for a hospice agency. Continuum did not justify the basis of

this projection, and thus did not base its financial projections upon reasonable projections of costs.

Comments Specific to Criterion 6

- Continuum did not adequately demonstrate that its projected utilization is reasonable, credible or adequately supported. Therefore, Continuum did not adequately demonstrate in its application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies. See Criterion 3 for additional discussion. Consequently, the Continuum application did not demonstrate that its proposed project will not result in unnecessary duplication of existing health services, and thus is not conforming to Criterion 6.

Comments Specific to Criterion 13

- Continuum did not reasonably project the extent to which the elderly and medically underserved groups expect to utilize the proposed services. Specifically, Continuum projects an unjustifiably high Medicaid payor mix of 7%, far higher than any other applicant. On page 92 of its application, Continuum states that its projected payor mix of 7% Medicaid *"is comparable to the recent payor mix of Rowan County hospice offices".* Yet on that same page Continuum includes a table showing the historical Medicaid payor mix (by patients served) as 5%, or nearly 30% lower than the Continuum projection. Hardly comparable. Continuum tries to justify its aggressive assumption by providing information regarding Rowan County demographics, including poverty rate and uninsured percentage (just as did Carolina Caring in its application). However, Continuum provides no evidence or supporting documentation regarding how it will serve a far higher Medicaid percentage than any existing Rowan County agency; it is simply manufacturing an unreasonable and unrealistic projection. The Continuum application is therefore not conforming to Criterion 13.

Comments Specific to Criterion 18a

- Continuum did not adequately demonstrate the effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost-effectiveness and access to services proposed. Continuum did not adequately demonstrate that projected utilization is reasonable, credible or adequately supported. Continuum did not adequately demonstrate in its

application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies, and did not demonstrate that its proposal is the most effective alternative. The applicant did not adequately demonstrate financial feasibility based upon a reasonable projection of costs and charges. Also, Continuum did not reasonably project the extent to which the elderly and medically underserved groups expect to utilize the proposed services. See Criteria 3, 4, 5, 6 and 13 for additional discussion. Consequently, the Continuum application is not conforming to Criterion 18a.

Personal Home Care of North Carolina (PHC) Project ID # F-11957-20

While PHC is a provider of home health services in North Carolina, it has no hospice experience, and is not licensed to operate any hospice agency in North Carolina. PHC's complete lack of hospice experience would mean that PHC would have to build from scratch an entire interdisciplinary hospice care team, which would likely lead to lost time in establishing a fully functioning hospice program. In comparison, Carolina Caring has a proven track record of dedicated service to the residents of North Carolina for over 40 years, and has extensive experience and expertise providing comprehensive hospice services in the western Piedmont area. PHC's lack of hospice experience is evident in its application, which provides little to no specifics regarding clinical orientation or continuing education content related to hospice, grief, death, dying, or symptom management. With PHC's lack of hospice experience, it is impossible for the Agency to know whether or not PHC is likely to be successful as a hospice agency in serving the Rowan County population.

PHC's application should not be approved as proposed. Carolina Caring identified the following specific issues, each of which contributes to the application's non-conformity to statutory review criteria.

Comments Specific to Criterion 1

- PHC does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. See discussion regarding Criterion 3. Therefore, PHC does not adequately demonstrate that its proposal would maximize healthcare value. Consequently, the application is not consistent with Policy GEN-3 and is not conforming to Criterion 1.

Comments Specific to Criterion 3

- PHC's application should not be approved as proposed, because the applicant projected an average length of stay (ALOS) of 81.3 days, which is unreasonably high, and indeed by far the highest of any applicant. On page 114 of its application, the applicant indicates this is based on *"experience by other hospice providers nationally."* PHC did not document how this broad national ALOS experience of many other states is in any way relevant or applicable to Rowan County. This unrealistic ALOS projection is apparently designed to increase the projected days of care. Therefore, PHC's ALOS projection is not supported.

  In summary, the high projected ALOS results in an unreasonably high projection of hospice days of care. PHC does not adequately demonstrate the need the projected

population has for the proposed hospice agency. Consequently, the application is not conforming to Criterion 3.

Comments Specific to Criterion 4

- The PHC application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. A project that cannot be approved cannot be an effective alternative. Consequently, PHC's application is not conforming to this criterion.

- As previously stated, PHC's lack of hospice experience makes it impossible for the Agency to ascertain whether or not PHC would be likely to be successful as a hospice agency in serving the Rowan County population. The risk is too great, and given that the batch review includes experienced North Carolina hospice providers, the PHC application is not the most effective alternative.

Comments Specific to Criterion 5

- The PHC application is not conforming to other statutory and regulatory review criteria, and thus, is not approvable. See discussion regarding Criterion 3. Specifically, based on its high ALOS assumption, PHC developed an unsupported projection of hospice days of care, which results in an unwarranted projection of costs and charges. A project that does not adequately demonstrate need cannot demonstrate financial feasibility. Consequently, the application is not conforming to this criterion.

- PHC projects 21% benefits and taxes percentage of salaries for its staff. This is an unreasonably high figure for a hospice agency. PHC did not justify the basis of this projection, and thus did not base its financial projections upon reasonable projections of costs.

Comments Specific to Criterion 6

- PHC did not adequately demonstrate that its projected utilization is reasonable, credible or adequately supported. Therefore, PHC did not adequately demonstrate in its application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies. See Criterion 3 for additional discussion. Consequently, the PHC application did not demonstrate that its proposed project will not

result in unnecessary duplication of existing health services, and thus is not conforming to Criterion 6.

Comments Specific to Criterion 18a

- PHC did not adequately demonstrate the effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost-effectiveness and access to services proposed. PHC did not adequately demonstrate that projected utilization is reasonable, credible or adequately supported. The applicant did not adequately demonstrate financial feasibility based upon a reasonable projection of costs and charges. PHC did not adequately demonstrate in its application that the Hospice Home Care Office it proposes to develop in Rowan County is needed in addition to the existing agencies, and did not demonstrate that its proposal is the most effective alternative. See Criteria 3, 4, 5, and 6 for additional discussion. Consequently, the PHC application is not conforming to Criterion 18a.

CONCLUSION

For all of the foregoing reasons, each of the competing applications should be disapproved. As noted in the preceding discussion, the competing applications are each non-conforming with multiple statutory review criteria. Carolina Caring's application is conforming with all applicable review criteria. With regard to conformity with review criteria, Carolina Caring is the only approvable application. The results of the comparative analysis show that Carolina Caring's application, with the lowest cumulative score, thus ranks as the most effective alternative. Also, Carolina Caring clearly has demonstrated a greater level of support and coordination with local healthcare providers and members of the Rowan County community, and therefore represents the most effective alternative in this regard. The Carolina Caring application can and should be approved because it satisfies all the applicable CON review criteria and is comparatively superior to each of the competing applications.

Attachment 1

Profiteering: Putting Financial Goals ahead of Quality Care for the Terminally Ill

PART 1 OF 2:

IS IT TIME TO DISRUPT THE MEDICARE HOSPICE BENEFIT TO PRESERVE THE LEGACY OF HOSPICE?

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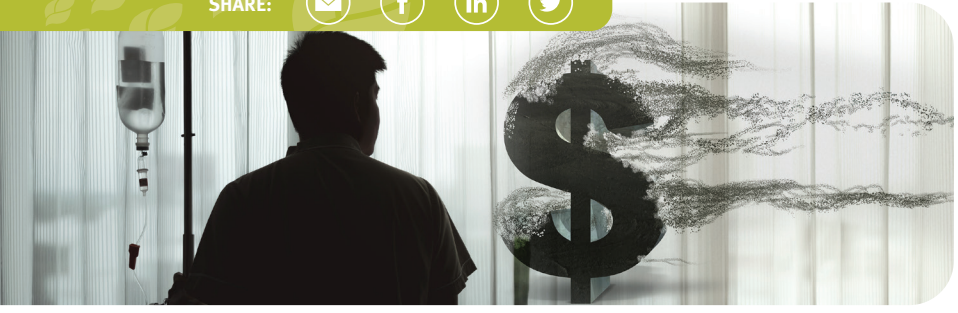
Congress approved the Medicare Hospice Benefit in 1981 to create an alternative to conventional curative treatment by providing quality, patient-centered, family-centered care for the terminally ill. The creation of the benefit was based on an unspoken covenant that care providers would utilize those Medicare dollars wisely. The benefit was focused on maintaining the comfort and dignity of the patient, as originally envisioned by the founder of the modern hospice movement, Dame Cicely Saunders.

But what happens to the good faith implicit in the Medicare Hospice Benefit when end-of-life care becomes a vehicle for corporate profiteering rather than a mandate to provide exceptional care to vulnerable patients and families?

The term "profiteering" refers to the act of making an unfair profit by taking advantage of a situation and exploiting someone unjustly. This practice is cited as a cause of inflated costs across the entire U.S. healthcare system. When profiteering is the primary business model used by those entrusted with caring for the dying, using aggressive systems to implement practices to avoid cost and increase profits, it raises questions regarding intent and vulnerability of those being served.[1] To be clear, the question addressed by this paper does not place blame specifically on the corporate business structure of hospices—whether for-profit or not-for-profit. It does deal with the underlying business strategies of certain hospice providers who put financial goals ahead of quality care for the terminally ill. This paper will explore profiteering practices utilized by certain hospices and the subsequent impact of those practices on the viability of the Medicare Hospice Benefit itself.

Part 2 (to be published at a later date) will explore the effect of profiteering on patient care and community-based, mission-driven, patient-centered hospices.



AN EDUCATIONAL INITIATIVE OF

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FINANCIAL MANIPULATION, LIMITING CARE AND SERVICES TO MAXIMIZE REVENUE

The unique structure of the Medicare Hospice Benefit, an all-inclusive benefit that reimburses providers on a per diem basis, has created the opportunity for exploitation through a number of profiteering practices. By accepting the per diem payment, hospices are responsible for all expenses related to the hospice patient's terminal diagnosis, including the hands-on care of nurses, nurses aides, social workers, chaplains and physicians; medical equipment; medical supplies; and prescription and over-the-counter medications. Providers can maximize profits either by limiting the services provided, admitting patients who require minimal care, increasing the number of days of care each patient receives—or a combination of these factors. In profit-focused hospices, the number of visits a patient receives, the amount and type of care provided, and the diagnoses of the patients admitted all can determine potential revenues and profit margins. A profit-maximizing business model does not necessarily factor in the needs of the patient, the patient's family, the healthcare community and the community are large.[2]

For example, two troubling reports issued by the Office of Inspector General (OIG) of the Centers for Medicare & Medicaid Services (CMS)[3] in the summer of 2019 garnered widespread media coverage because of shocking stories of negligent care and performance deficiencies detailed in the report. Poor management of pain, missed visits, lack of quality controls, and inadequate vetting and training of staff were just some of the problems noted in the report—problems that were compounded by weak oversight from CMS. The adoption by certain providers of a business model based on cutting corners on appropriate care to maximize profit largely has gone unrecognized and unpunished in the past. It, nevertheless, is an abuse of public funds intended for the compassionate care of the dying and it also is a betrayal of the good faith and trust placed in the hospice community through the creation of the Medicare Hospice Benefit.

There are also numerous examples in the OIG reports and elsewhere of hospices enrolling patients who are likely to have very long lengths of stay while requiring minimal care.[4] In addition, some hospices have been found to discharge patients when they require more care.[5] The malicious intent to maximize profit is evident in these business strategies, which results in a shifting of dollars intended for the care of the dying to the coffers of profit-focused organizations.

Many of these profit-focused hospices often don't even make the effort to hide their focus on profit-making. For example, Rich Tinsley, president of a healthcare mergers and acquisitions firm, in April of 2018 lamented, "Margins in hospice also could be within the 15 to 20% range, though few in the industry are hitting that mark. Nonprofit hospice providers still make up a significant portion of the space, which may be one reason margins aren't as high, as organizations aim to fulfill their missions rather than turn a profit."[6] Some hospices even have a rage-inducing view of the cost of doing business. Commenting on a $75 million fraud settlement, the CEO of Vitas, one of the nation's largest hospice companies, stated, "The $75 million settlement over a decade of billings should be kept in perspective with more than $1 billion in annual revenue at the nation's largest hospice provider."[7] These statements give the impression that not only should profits be higher, but that some costs are worth the risk when weighed against the potential for substantial revenue gains.

"For those of us in the hospice movement who have devoted ourselves to the mission of delivering quality care to the dying, the 2019 OIG reports, as well as older, similar reports, are more than troubling and discouraging. When these official reports are combined with the boastful comments from companies about their profit-making strategies, we're shocked—and dismayed—that we haven't seen greater, more concentrated efforts to limit profiteering and curb these acts of maleficence," said Jeff Lycan, president of the National Hospice Cooperative (NHC). All of the ethical underpinnings of our society come into play when we talk about care at the end of life," Lycan continued. "It involves the right to quality, compassionate care, recognizing the vulnerability of the patient and family, and the responsibility of the provider to deliver appropriate care. These are the values that are under fire when profit-making is prioritized over patient care."

"The data analysis in the Washington Post study, which was based on hundreds of thousands of Medicare patient and hospice records, showed a striking and consistent gap between for-profit and not-for-profit providers."

Dying and profits—The evolution of hospice
Washington Post
December 26, 2014

The 2019 OIG reports were issued five years after the Washington Post began publishing a year-long, intermittent series, "Business of Dying,"[8] which, among other issues, examined the business practices of profit-focused hospices. The data analysis in the Washington Post study, which was based on hundreds of thousands of Medicare patient and hospice records, showed a striking and consistent gap between for-profit and not-for-profit providers. Based on the data, The Washington Post concluded that the typical for-profit hospice company:

- Spends less on nursing care per patient;
- Is less likely to have sent a nurse to a patient's home in the last days of life;
- Is less likely to provide more intense levels of care (general inpatient care and continuous or crisis care) for patients undergoing a crisis; and
- Has a higher percentage of patients who are discharged from hospice care before dying. High rates of patient discharges are often seen as a sign that patients were either pushed out of hospice by a hospice provider when the patients' care grew too expensive, dissatisfied with the care being provided or enrolled in hospice even though they were not eligible for end-of-life care.

THE THREAT TO THE HOSPICE COMMUNITY

The dying process is uncertain and unpredictable. In caring for dying patients, hospices may spend more than the per diem rate to meet the needs of some patients experiencing a spike in pain and other symptoms or who are actively dying. And hospices may spend less than the per diem rate in caring for more stable patients. Hospice providers committed to meeting the community's broad need for quality end-of-life care will overspend on some patients knowing that others will require less costly services. The Medicare Hospice Benefit, as it stands today, requires this balancing act to provide the highest level of patient care. This balance of care, however, is upset when profit-focused hospice companies compete for patients requiring less care and discharge those with more expensive care requirements.[9]

This places many not-for-profit hospice providers at risk due to a financial imbalance in the ratio between patients needing more care and patients requiring less care. Some may have to make difficult choices about the number of patients with expensive needs they can admit, the breadth of the service area they can cover and the scope of non-covered services like grief and bereavement they can offer. The risk is that the overall quality of care provided to patients begins to erode because of inequities in coverage choices and reimbursement. The risk is particularly exacerbated, as indicated in the OIG reports, when too many dollars flow into the pockets of the owners of for-profit hospice companies rather than toward the needs of dying patients.

If this trend continues, hospice will move farther from the original mission envisioned when the nation's first community-based hospice opened its doors in 1974. If the profit-focused business model prevails, we'll undoubtedly see the hospice sector become less relevant and more unstable due to a broken financial model, a financial model that does not align with the broad needs of the target population. In that broken future, large numbers of patients who are not truly eligible for hospice care could receive minimal care for long periods of time while dying patients with high needs will be discharged from care before their cost of care becomes a threat to profits. As a result, terminally

ill patients will lose, the entire healthcare system will lose, but investors and shareholders of all types of profit-focused hospices most assuredly will win. The threat to the hospice mission is real and should concern all responsible hospice providers, both for-profit and not-for-profit.

THE THREAT TO THE MEDICARE HOSPICE BENEFIT

When the Medicare Hospice Benefit initially was established, Congress noted several reservations, including cost-efficiency, fair and equitable reimbursements, and adequate financing.[10] These concerns still influence ongoing support for the Medicare Hospice Benefit and are the basis of periodic legislative and regulatory reevaluations of the program.

The long-term sustainability of the hospice benefit is under threat, not only from issues of inadequate quality of care, but also from fraudulent billing practices by some hospice organizations. The OIG has cited numerous instances of fraud schemes. Some hospice companies enroll ineligible patients, pay recruiters to solicit ineligible beneficiaries and/or pay physicians to falsely certify patients as hospice eligible.[11]

"The OIG has cited numerous instances of fraud schemes. Some hospice companies enroll ineligible patients, pay recruiters to solicit ineligible beneficiaries and/or pay physicians to falsely certify patients as hospice eligible."

Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio

OIG Report

July 30, 2018

While the OIG has investigated and fined many of these companies, reports of fraudulent billing practices continue to grow and pose a significant risk to the Medicare hospice budget and the care it funds for terminally ill patients and their families. [12] [13]

Another concern is when some investor-owned hospice companies report profit margins of 15–20 percent—or higher. High profit margins create the false impression that Medicare may be paying too much for hospice care. There is a substantial probability that CMS could choose to lower reimbursements to reduce such unseemly profit margins. As a result, the patient-centered hospices that already bear the burden of the sickest and costliest patients and that subsist on the thinnest of profit margins will receive even less revenue to cover the care they provide. Profiteering practices thus create a vicious cycle of self-consumption that eventually could destroy the Medicare funding that provides 90 percent of end-of-life care in the United States.

CONCLUSION

While this paper is not specifically about ownership status of the nation's 5,000 Medicare-certified hospices, many of the markers used to evaluate the quality and cost effectiveness of hospice ultimately demonstrate the divide between how for-profit and not-for-profit hospices operate. The Medicare Payment Advisory Committee (MedPAC) notes the difference in for-profit and not-for-profit margins in its annual reports to Congress. For example, in its March 2019 report, MedPAC stated that the margins of for-profit companies ranged from 16.8 to 17.6 percent, while the margins of not-for-profit providers ranged from 2.7 to 6.4 percent.[14]

"For mission-driven hospices, numbers like these are worrying—and bordering on dangerous," Lycan warned. "Even the concept of 'total cost of care per day' is a somewhat biased indicator in the MedPAC report if we consider profiteering as a motive. MedPAC should move to measuring the Medicare Spend per Beneficiary (MSPB) to incorporate the effects of live discharge rates, post hospice emergency room and hospitalization," he added.

The for-profit average cost per patient per day is $133; the not-for-profit cost per patient per day is $170. The Medicare Hospice Benefit, however, pays a per diem rate that is the same for all hospices—regardless of ownership status. From the perspective of those who look at healthcare spending as an entitlement that needs to be cut, the data appear to make

a compelling case for a significant reduction in the Medicare Hospice Benefit per diem reimbursement. But if the focus is quality of care and meeting demonstrated community need for comprehensive end-of-life care, then the real question is whether $133 per day is far too low a figure. Are the much higher margins of the profit-focused hospices an indicator of more efficient care or the result of high live discharge rates and shunning of costs? Or are those higher margins an indicator of care that falls below—sometimes well below—the values that are at the heart of the Medicare Hospice Benefit?

"When the sickest and most vulnerable individuals of our society are exploited for financial gain, everyone loses. In a competitive marketplace that is dominated by profiteering, the patient-centered hospice that prioritizes compassionate and dignified care of the dying eventually will not be able to survive," cautioned Lycan. The Medicare Hospice Benefit itself will be consumed by the profiteering of for-profit hospices—the inevitable decline in quality and scope of care ultimately will lead to the benefit's demise. These are real threats to the terminally ill and the mission-driven hospices that formed the hospice movement and have set the standard for quality, compassionate, timely end-of-life care for more than 40 years. As a result, these are threats to the Medicare Hospice Benefit itself.

These threats must be addressed now before it is too late to preserve the legacy of Cicely Saunders, whose simple goal was to help people "die peacefully" and "to live until they die."

Profiteering as a business strategy of certain for-profit hospices eventually could destroy hospice as we know it, threatening not just quality, compassionate end-of-life patient care but also the community-based, mission-driven, patient-centered hospice organizations that built hospice care across America. This will be the focus of Part 2 of this report.

ABOUT NATIONAL HOSPICE COOPERATIVE

Our mission is to provide world-class, business support services, maximizing financial and process efficiencies to empower community-based, not-for-profit hospice providers to focus their resources on the delivery of quality care.

REFERENCES

[1] https://nonprofitquarterly.org/ugly-face-profiteering-hospice-care-profit-effects-field/

[2] https://jamanetwork.com/journals/jama/fullarticle/645420

[3] https://www.oig.hhs.gov/oei/reports/oei-02-17-00020.asp?utm_source=whatsnew&utm_medium=web&utm_campaign=OEI-02-17-00020

[4] https://www.nejm.org/doi/full/10.1056/NEJMp0902437

[5] https://homehealthcarenews.com/2017/07/hospices-may-profit-from-live-discharges/

[6] https://homehealthcarenews.com/2018/04/buyers-snatch-up-unprofitable-hospices-in-hot-ma-market/

[7] https://www.palmbeachpost.com/business/vitas-hospice-scrutinized-post-reaches-record-doj-settlement/9ZCScj50P51RxEDWOHjOZP/

[8] https://www.washingtonpost.com/sf/business/collection/business-of-dying/?utm_term=.0afb92e1f0aa

[9] https://www.verywellhealth.com/for-profit-vs-non-profit-hospice-1132287

[10] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/CMS1192048dl.pdf

[11] https://oig.hhs.gov/oei/reports/oei-02-16-00570.asp

[12] https://www.justice.gov/usao-wdpa/pr/hospice-company-and-owner-agree-pay-124-million-settle-two-false-claims-act

[13] https://www.justice.gov/opa/pr/chemed-corp-and-vitas-hospice-services-agree-pay-75-million-resolve-false-claims-act

[14] MedPAC, Chapter 12, March 2019 report. http://www.medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf

Profiteering: Patient-Centered vs. Profit-Driven Hospice Care: Part Two of Two

AN EDUCATIONAL INITIATIVE OF

NATIONAL HOSPICE Cooperative

Time to Educate, Advocate and Act to Protect the Legacy of Hospice

Hospice patients are among the most vulnerable in healthcare today. As they face the end of life, their highest priority is to live their final days as comfortably as possible in familiar surroundings. Yet considerable research indicates that the for-profit hospice movement, which today has grown to represent two-thirds of the nation's hospices, has a significantly different priority: their bottom line.

This profit motive is having a negative effect on the quality of care that patients using for-profit hospices receive, and it is also adversely affecting the hospice movement's ability to prepare for the future. According to a study published in the Journal of the American Medical Association (JAMA), for-profit hospices are less likely to provide staff or physician education or to conduct research.[1]

The National Hospice Cooperative has compiled the most salient data points from the in-depth research of several major organizations, including The Washington Post, The New York Times, The New England Journal of Medicine, JAMA, and the U.S. Department of Health and Human Services Office of Inspector General. All research points to significant differences between not-for-profit and for-profit hospices in the areas of patient care, breadth of services, staff training, physician education, and clinical research.

While not-for-profits follow the "compassionate care" tenet of Dame Cicely Saunders, founder of the hospice movement, for-profit hospices are beholden to shareholders who expect financial remuneration.

The research indicates that compassionate, quality care is getting lost in this profit-driven atmosphere, particularly evident when reviewing these major findings at the for-profit hospices:

- A higher live-discharge rate – the number of patients leaving hospice before dying.[2]
- Reduced access to nurses.[3]
- A narrower range of services in such areas as pain management and bereavement support.[4 5]
- Less training for hospice care providers.[6]
- Less support for research to improve quality.[7]
- Larger numbers of patients in nursing homes and assisted living facilities rather than at home, indicating a reliance on these facilities to provide daily support, which saves the for-profit hospice money.[8]

The negative news coverage generated by the studies that have identified these discrepancies affects all hospices, eroding the trust patients and families have in the overall hospice model of care. It is time for the not-for-profit hospice community to lead the way in educating providers, patients and families about the value of hospice care for both individuals and communities, to advocate for greater transparency and accountability, and to take action to ensure the best possible experience for all patients at the end of life.

This paper is the second in a two-part series focused on the effects of the profit motive in hospice care. Part 1 discussed the negative consequences of the Medicare Hospice Benefit structure, and whether it is a viable method of funding hospice care. Part 2 explores the impact of the for-profit motive on quality care, staff and physician education, and research.

Research Findings on Patient Care Quality

The Live-Discharge Rate

According to The Washington Post, which has published an extensive series of investigative reports under the title, "The Business of Dying," more than one in three patients are being discharged from hospices before death. This live-discharge rate is a "sign of trouble," according to The Washington Post.[9]

While it is normal for about 15 percent of hospice patients to be discharged before dying, often because their health improves, researchers with The Washington Post found that at some hospices, particularly those managed by newer, for-profit companies, the rate is double that or even higher. Mississippi and Alabama, for example, had rates of 41 and 35 percent respectively.[10]

Based on its analysis of more than 1 million U.S. hospice records from 2002 to 2012 and more recent supportive information from the federal government, The Washington Post attributes this discrepancy to two key factors:

- For-profits seek to avoid paying for the more expensive care that patients often need as they approach death, and
- For-profits actively recruit patients who aren't actually terminally ill.[11]

Avoiding costly care

As patients' health deteriorates, their care needs can increase, both in quantity and cost. Researchers found that one in four patients discharged from hospice before death are subsequently admitted to a hospital within 30 days.[12] Through early discharge, the for-profit hospice avoids providing costly CT-scans, MRIs, and palliative radiation treatments. However, patients often then end up in emergency rooms and hospitals – the polar opposite of their originally expressed desire for comfort and familiarity at the end of life.[13]

Recruiting healthier patients

Research studies by The Washington Post, the federal government and other organizations indicate that some for-profit hospices are enrolling patients who are not terminal.[14] This allows these hospices to collect the per-diem rate established by the Medicare Hospice Benefit, while not providing the more expensive care that critically ill and/or dying patients often require.[15]

Additional research by MedPAC – the Medicare watchdog group established by Congress – supports this healthy-patient recruitment concern. According to MedPAC, the average number of days patients are staying in hospice is increasing, particularly at the for-profits. The average length of stay in a for-profit hospice is 102 days compared with just 69 days in not-for-profit care.[16] Longer lengths of stay for less sick patients yield more revenue, but this puts non-terminally ill patients in the wrong healthcare setting.

In combination, these two documented practices in for-profit hospices – discharging patients before death and enrolling patients who are not actually dying – serve to increase profitability while decreasing the overall quality of hospice patient care.

Reduced Access to Nursing Care and a Narrower Range of Care Services

In research conducted by The Washington Post, Yale University School of Medicine, and the Icahn School of Medicine at Mt. Sinai in New York, discrepancies were found between for-profit and not-for-profit hospices tied to nursing care, pain management, bereavement support, and the array of treatment options offered. Key points from this research:

- **Final days of life:** While both not-for-profit and for-profit hospices sent nurses to see patients at some point during the last two days of life, a patient at a for-profit hospice was 22 percent less likely to see a nurse in that critical time period, indicating a lower level of responsiveness.[17]
- **Per-day spend:** For-profit hospices spent 17 percent less per patient per day on nursing visits; not-for-profit hospices spent about $36 per day per patient, while for-profit hospices spent just $30 per day.[18]
- **Range of patient and family services:** Patients at for-profits hospices were also less likely to receive the full array of treatment options for pain and symptom management that were offered in not-for-profit settings.[19] Not-for-profit hospices also provided more intense services, such as continuous nursing and inpatient care, for those patients with difficult-to-control symptoms.[20] Specifically, not-for-profits offered about 10 times as much of this type of care per patient-day as the for-profits.[21] Finally, for-profit hospices were less likely to offer comprehensive bereavement services to families.[22]

Less Training for Hospice Care Providers

Other tactics for reducing expenditures at the for-profit hospices, according to the research, included hiring fewer professionally trained staff members, recruiting new graduates who would work for lower pay, and not offering on-site clinical training for hospice and palliative medicine physicians.[23] [24] Not-for-profit hospices were more likely to serve as training sites for hospice care providers than for-profit hospices, which has long-term implications for patient care.[25]

The nation is currently facing a shortage of approximately 12,000 hospice and palliative medicine physicians, and just 180 fellows are graduating in this field annually – not enough to replace the number of retirees.[26] At just 31 percent of the total number of U.S. hospices, not-for-profit hospices cannot shoulder the burden of on-site clinical training alone, given the need for an even larger hospice workforce in coming years.[27]

Less Support of Research to Improve Quality

As the hospice field grows, the need for research also expands – specifically to ensure ongoing quality improvement. Studies indicate that for-profits are less likely to conduct research for publication than not-for-profits,[28] and as with clinical training, this places a significant financial and coordination burden on the not-for-profits hospices to continually seek the best ways to provide end-of-life care.

Larger Numbers of Patient in Nursing Homes, Assisted Living Facilities

Home-based hospice care is typically more expensive to provide than care given in a nursing home or assisted living facility.[29] First, home-based care requires more travel time on the part of the hospice staff.[30] Second, the staff of the nursing home or assisted living facility often provide some of the primary support for a patient's personal care needs, relieving the hospice provider of that kind of work.[31] Research shows that, to maximize revenue, for-profit hospices tend to recruit patients in nursing homes and assisted living facilities and to provide less home-based care than the not-for-profit hospices.[32] Once again, this puts the burden on the not-for-profits in the field to provide the more complex, expensive care, while also shouldering greater responsibility for staff and physician training and clinical research.

Advocating for Change, Transparency to Ensure Quality Hospice Care for All

Providing all terminally ill patients with compassionate, quality care at the end of life was the vision of Dame Saunders and is the commitment not-for-profit hospices have made to patients and families for years. Still, hospice and palliative care continue to suffer from a lack of full understanding and from a range of misperceptions – all of which lead to fewer than half of terminally ill hospitalized patients receiving a referral to hospice.[33]

News coverage about hospice deficiencies, while vital to advancing information, adds to the confusion and erodes the trust that is so important between patients, families and hospice care providers. Unless we in the hospice field recognize the urgency of addressing these problems and take effective action, the original patient-centered hospice movement could be permanently damaged by profit-driven motives of a growing segment of the industry.

Ultimately this question cannot be ignored: Does it exceed the ethical boundaries of the hospice movement, whose legacy lies in putting the patient first, to allow market-driven companies to control end-of-life care? Certainly the statistics presented here should raise concern among those who believe that the dying deserve to be treated with dignity and compassion and not as a target for potential profits.

Now is the time to stand up, together, for the rights of dying patients, support patient-centered hospice organizations who are providing quality care for those patients, and reject the profit-focused practices of the companies who are exploiting this situation of need. Policymakers, regulators, community leaders, and healthcare providers must take up the cause and protect the legacy of compassionate, high-quality care for the dying.

References

1 https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1832198

2 https://homehealthcarenews.com/2017/07/hospices-may-profit-from-live-discharges/

3 https://newoldage.blogs.nytimes.com/2014/03/03/differences-in-care-at-for-profit-hospices/

4 https://oig.hhs.gov/oei/reports/oei-02-16-00570.asp

5 https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1832198

6 https://www.washingtonpost.com/business/economy/is-that-hospice-safe-infrequent-inspections-means-it-may-be-impossible-to-know/2014/06/26/e258e880-eaa4-11e3-b98c-72cef4a00499_story.html

7https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1832198

8 https://oig.hhs.gov/oei/reports/oei-02-14-00070.pdf

9 https://www.washingtonpost.com/business/economy/leaving-hospice-care-alive-rising-rates-of-live-discharge-in-the-us-raise-questions-about-quality-of-care/2014/08/06/13a4e7a0-175e-11e4-9e3b-7f2f110c6265_story.html

10 Ibid

11 Ibid

12 Ibid

13 Ibid

14 Ibid

15 Ibid

16 https://www.washingtonpost.com/business/economy/2014/12/26/a7d90438-692f-11e4-b053-65cea7903f2e_story.html

17 https://www.washingtonpost.com/business/economy/2014/12/26/a7d90438-692f-11e4-b053-65cea7903f2e_story.html

18 Ibid

19 https://oig.hhs.gov/oei/reports/oei-02-16-00570.asp

20 https://www.washingtonpost.com/business/economy/2014/12/26/a7d90438-692f-11e4-b053-65cea7903f2e_story.html

21 Ibid

22 https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1832198

23 https://www.washingtonpost.com/business/economy/is-that-hospice-safe-infrequent-inspections-means-it-may-be-impossible-to-know/2014/06/26/e258e880-eaa4-11e3-b98c-72cef4a00499_story.html

24 https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1832198

25 Ibid

26 Ibid

27 Ibid

28 Ibid

29 Ibid

30 Ibid

31 ibid

32 Ibid

33 https://www.amjmed.com/article/S0002-9343(18)30756-3/fulltext

About National Hospice Cooperative

Our mission is to provide world-class, business support services, maximizing financial and process efficiencies to empower community-based, not-for-profit hospice providers to focus their resources on the delivery of quality care.

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Attachment 2

Segment Growth

By **Jim Parker** | May 22, 2019

LHC Group

Share

Amedisys Inc., (NASDAQ: AMED),the third largest provider of hospice and home health in the United States, is prioritizing expansion of its hospice footprint through acquisitions and de novo activity, as the company cools down its home health care acquisition efforts due to uncertainties regarding the patient driven groupings model (PDGM).

A focus on hospice growth will help balance the company's portfolio, which leans toward home health. The company's first quarter 2019 revenue for hospice was $138 million, compared to $310 million for home health care.

"We are really going to feed the beast in hospice. Right now from an M&A perspective, from where should we be focusing on de novos, on tuck-ins, on deals, on integrations—we are pushing hospice," said CEO Paul Kusserow in a presentation at the RBC Capital Markets Global Healthcare Conference. "Then this time next year we will understand

Effective Jan. 1, 2020 Medicare will begin reimbursing home health care providers through PDGM, which classifies patients into payment categories based on clinical characteristics and other patient information, and shifts the home health payment model to a 30-day payment period rather than the current 60-day episode.

Home health care providers have been concerned about the transition amid predictions of increased bankruptcies, the use of behavioral assumptions in patient grouping methods, increased regulatory scrutiny, and potential payment cuts.

Amedisys continues to be on the lookout for acquisition opportunities following its $340 million purchase of Compassionate Care Hospice in

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it," Kusserow said. "The price was fantastic. I hope there is another one out there like it at that size at that price."

Compassionate Care's average daily census exceeded the company's expectations by 200 patients at the time of the transaction's closing. The hospice contributed $4.2 million to the Amedisys' $13 million year-over-year increase in EBITDA.

Following the RoseRock tuck-in, Amedisys operates 138 hospice care centers in 34 states.

Industry observers such as the Braff Group and Mertz-Taggart have predicted that mergers and acquisitions will continue to be a leading growth strategy throughout the hospice market during 2019 and beyond.

Amedisys will likely not be alone in focusing on hospice growth as PDGM approaches. In a February report the M&A advisory firm the Braff Group indicated that the hospice acquisitions market will likely outstrip the home health care sector due to concerns about the new payment model.

out doing denovos—7 to 9 de novos this year. And we are looking or more tuck ins."

Companies featured in this article:

Amedisys, Compassionate Care Hospice, RoseRock Healthcare

Jim Parker

Jim Parker is a subculture of one. Swashbuckling feats of high adventure bring a joyful tear to his salty eye. A Chicago-based journalist who has covered health care and public policy since 2000, his personal interests include fire performance, the culinary arts, literature, and general geekery.

Amedisys Expanding Hospice Referral Network in Response to COVID-19

By Jim Parker | October 29, 2020

Post-acute care company Amedisys (NASDAQ: AMED) will be growing its referral network to include more non-institutional providers due to a shifting patient mix brought on by COVID-19. The pandemic has led to a drop in referrals from institutional health care providers, but created an uptick among other organizations that transition eligible patients to hospice.

The company's facility-based patient census fell to 35% during the third quarter of the year from 43% in the prior year's quarter; non-facility business rose to 64% in Q3, up from 57% during the same period in 2019. This trend has prompted Amedisys to employ new outreach strategies as the company steps up its business development workforce with 73 new hires.

"We have leveraged our additional 73 [business development] feet-on-the-street towards two strategies," CEO Paul Kusserow said on an earnings call. "One: Focus on continuing to steal market share in facilities and to expand our referral base to new non-facility-based accounts, and in all cases continuing to educate all referral sources on identifying the need for hospice earlier."

Amedisys saw a 9% boost in same-store admissions during the third quarter; a corresponding rise in average daily census will be reflected in fourth quarter results as census data tends to lag behind admissions numbers by one quarter, according to Kusserow, who indicated that he expects strong hospice census growth through the end of the year and into 2021.

Kusserow expressed optimism for hospice in 2021 on the company's third quarter earnings conference call, citing strong demographic tailwinds and favorable revised rates.

Hospice payment rates will go up 2.4% during Fiscal Year 2021 according to a final rule issued by the U.S. Centers for Medicare & Medicaid Services (CMS). The change would increase annual Medicare hospice spending by $540 million, though providers that do not meet quality reporting requirements will see a 2% reduction to the 2021 per diems, as CMS typically mandates.

Amedisys expects the rate hike, coupled with positive changes to home health reimbursement, to produce estimated incremental revenues of $40 million during 2021.

The payment increase comes with a corresponding 2.4% bump to the aggregate payment cap. The cap limits the overall payments made to a hospice annually. The final hospice cap amount for the FY 2021 is $30,683.93. The 2020 cap was set at $29,964.78.

"Positive rate updates are increasingly impactful and meaningful to our business and position us well for top- and bottom-line growth in 2021," Kusserow said. "The 2021 rate updates for both home health and hospice are just a small piece of why we continue to be increasingly excited about what the next few years appear to have in store for our company."

Attachment 3

JUSTICE NEWS

Department of Justice
Office of Public Affairs

FOR IMMEDIATE RELEASE
Wednesday, April 23, 2014

Amedisys Home Health Companies Agree to Pay $150 Million to Resolve False Claims Act Allegations

Amedisys Inc. and its affiliates (Amedisys) have agreed to pay $150 million to the federal government to resolve allegations that they violated the False Claims Act by submitting false home healthcare billings to the Medicare program, the Department of Justice announced today. Amedisys, a Louisiana-based for-profit company, is one of the nation's largest providers of home health services and operates in 37 states, the District of Columbia and Puerto Rico.

"It is critical that scarce Medicare home health dollars flow only to those who provide qualified services," said Stuart F. Delery, Assistant Attorney General for the Civil Division. "This settlement demonstrates the department's commitment to ensuring that home health providers, like other providers, comply with the rules and don't misuse taxpayer dollars."

The settlement announced today resolves allegations that, between 2008 and 2010, certain Amedisys offices improperly billed Medicare for ineligible patients and services. Amedisys allegedly billed Medicare for nursing and therapy services that were medically unnecessary or provided to patients who were not homebound, and otherwise misrepresented patients' conditions to increase its Medicare payments. These billing violations were the alleged result of management pressure on nurses and therapists to provide care based on the financial benefits to Amedisys, rather than the needs of patients.

Additionally, this settlement resolves certain allegations that Amedisys maintained improper financial relationships with referring physicians. The Anti-Kickback Statute and the Stark Statute restrict the financial relationships that home healthcare providers may have with doctors who refer patients to them. The United States alleged that Amedisys' financial relationship with a private oncology practice in Georgia – whereby Amedisys employees provided patient care coordination services to the oncology practice at below-market prices – violated statutory requirements.

"Combating Medicare fraud and overbilling is a priority for my office, other components of the Department of Justice, and United States Attorneys' Offices across the country," said Zane David Memeger, United States Attorney for the Eastern District of Pennsylvania. "We have recovered billions of dollars in federal health care funds from schemes such as the one alleged in this case. Those are health care dollars that should be spent on legitimate medical needs."

"Home health services are a large and growing part of our federal health care system," said Sally Quillian Yates, United States Attorney for the Northern District of Georgia. "Health care dollars must be reserved to pay for services needed by patients, not to enrich providers who are bilking the system."

"Amedisys made false Medicare claims, depriving the American taxpayer of millions of dollars and unlawfully enriching Amedisys," said Joyce White Vance, U.S. Attorney for the Northern District of Alabama. "The vigorous enforcement work by assistant U.S. attorneys in my office, along with their colleagues in North Georgia, Eastern Pennsylvania, Eastern Kentucky and the Civil Division of the Justice Department, has secured the return of $150 million to the taxpayers and stands as a warning to future wrongdoers that we will aggressively pursue them."

"This settlement represents a significant recovery of public funds and an important victory for the taxpayers," said Kerry B. Harvey, United States Attorney for the Eastern District of Kentucky. "Fighting health care fraud and recovering tax payer dollars that fund our vital health care programs is one of the highest priorities for our district."

Amedisys also agreed to be bound by the terms of a Corporate Integrity Agreement with the Department of Health and Human Services – Office of Inspector General that requires the companies to implement compliance measures designed to avoid or promptly detect conduct similar to that which gave rise to the settlement.

"Improper financial relationships and false billing, as alleged in this case, can shortchange taxpayers and patients," said Daniel R. Levinson, Inspector General for the U.S. Department of Health and Human Services. "Our compliance agreement with Amedisys contains strong monitoring and reporting provisions to help ensure that people in Federal health programs will be protected."

This settlement resolves seven lawsuits pending against Amedisys in federal court – six in the Eastern District of Pennsylvania and one in the Northern District of Georgia – that were filed under the *qui tam*, or whistleblower, provisions of the False Claims Act, which allow private citizens to bring civil actions on behalf of the United States and share in any recovery. As part of today's settlement, the whistleblowers – primarily former Amedisys employees – will collectively split over $26 million.

This settlement illustrates the government's emphasis on combating health care fraud and marks another achievement for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced in May 2009 by Attorney General Eric Holder and Secretary of Health and Human Services Kathleen Sebelius. The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in this effort is the False Claims Act. Since January 2009, the Justice Department has recovered a total of more than $19.2 billion through False Claims Act cases, with more than $13.6 billion of that amount recovered in cases involving fraud against federal health care programs.

The United States' investigation was conducted by the Justice Department's Commercial Litigation Branch of the Civil Division; the United States Attorneys' Offices for the Eastern District of Pennsylvania, Northern District of Alabama, Northern District of Georgia, Eastern District of Kentucky, District of South Carolina, and Western District of New York; the Department of Health and Human Services' Office of Inspector General; the Federal Bureau of Investigation; the Office of Personnel Management's Office of Inspector General; the Defense Criminal Investigative Service of the Department of Defense; and the Railroad Retirement Board's Office of Inspector General.

The lawsuits are captioned *United States ex rel. CAF Partners et al. v. Amedisys, Inc. et al.* 10-cv-2323 (E.D. Pa.); *United States ex rel. Brown v. Amedisys, Inc. et al.,* 13-cv-2803 (E.D. Pa.); *United States ex rel. Umberhandt v. Amedisys, Inc.,* 13-cv-2789 (E.D. Pa.); *United States ex rel. Doe et al. v. Amedisys, Inc.*, 13-cv-3187 (E.D. Pa.); *United States ex rel. Ognen et al. v. Amedisys, Inc. et al.* 13-cv-4232 (E.D. Pa.); *United States ex rel. Lewis v. Amedisys, Inc.,* 13-cv-3359 (E.D. Pa.); and *United States ex rel. Natalie Raven et al. v. Amedisys, Inc. et al.*, 11-cv-0994 (N.D. Ga.). The claims settled by the agreement are allegations only, and there has been no determination of liability.

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