BEFORE THE MARYLAND HEALTH CARE COMMISSION

IN THE MATTER OF	*	
THE APPLICATION OF	*	
AMEDISYS MARYLAND, LLC	*	**Docket No. 16-16-2382**
TO ESTABLISH A GENERAL	*	
HOSPICE PROGRAM IN	*	
PRINCE GEORGE'S COUNTY	*	

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RESPONSE TO INTERESTED PARTY COMMENTS OF MONTGOMERY HOSPICE AND BAYADA HOSPICE

Pursuant to COMAR §10.24.01.08F(3), Amedisys Maryland, LLC, d/b/a Amedisys Hospice of Greater Chesapeake ("Amedisys") responds to the Interested Party Comments filed by Montgomery Hospice ("MH") and Bayada Hospice in opposition to the Amedisys application for a certificate of need to establish a general hospice program in Prince George's County.

RESPONSE TO MONTGOMERY HOSPICE COMMENTS

1. Charity Care Commitment

MH suggests that Amedisys lacks a "demonstrated commitment" to charity care such that it does not satisfy COMAR 10.24.13.05J (Charity Care and Sliding Fee Scale). MH is incorrect. The standard requires the applicant to: (1) make a commitment to provide hospice to indigent patients; (2) demonstrate that its track record in the provision of charity care services, if any, supports the credibility of its commitment; and (3) have a specific plan for achieving the level of charity care to which it has committed.

Amedisys has satisfied each of these requirements. It made a commitment in its Application to provide hospice to indigent patients in Prince George's County. In 2020, its commitment of $42,705 in charity care equates to 1.5% of patient days. See Application Table

4. This is a meaningful commitment to charity care, and satisfies the State Health Plan standard. The fact that MH shows a higher amount of charity care as a percentage of revenues than Amedisys is not relevant to whether Amedisys has satisfied this standard.[1]

Likewise, Amedisys has demonstrated a track record of providing charity care in its existing jurisdictions. In 2015, it provided 239 days of care to 3 charity care patients, .51% and .33%, respectively. Application at 21. This demonstrates that Amedisys has a track record of providing charity care, even in jurisdictions in which it is not subject to any regulatory obligation to do so. Amedisys has never turned down a charity care patient in any of its existing jurisdictions.

Amedisys recognizes that it has made a larger commitment to charity care in Prince George's County than it provided in its existing jurisdictions in 2015, but nothing in the standard prohibits an applicant from making a larger commitment than what it has provided in the past (indeed, the standard anticipates that an applicant may have no track record by using the words "if any"). As required by this standard, Amedisys has a demonstrated track record of providing charity care in Maryland, and has made a commitment to increasing its charity care level in Prince George's County.

Additionally, Amedisys provided a specific plan to achieve its charity care commitment by including it in its project budget. See Application, at 21, and Tables 3 and 4. MH provided no more than that in its application (see MH Application at 17). Indeed, MH argues that <u>its</u> inclusion of <u>its</u> charity care commitment in <u>its</u> budget "is a clear statement showing how thoroughly it is committed to providing charity care in Prince George's County." (See second

[1]MH also proposes to serve nearly <u>400% more patients</u> in 2020 than does Amedisys.

unnumbered page of MH's Comments). Accordingly, Amedisys has provided the same "clear statement" as MH claims to have provided.

Amedisys also notes that, as described in its application, it has included two FTEs in its budget for community outreach and marketing. These employees will be educated about Amedisys' charity care policy and its commitment to provide charity care in Prince George's County. As they meet with potential referral sources and community members and organizations, part of their responsibilities will be to inform the public about the availability of charity care from Amedisys.

2. Public Education

MH incorrectly claims that Amedysis has not documented a plan to provide public education programs as required under COMAR 10.24.13.05N regarding public education programs.

MH starts by giving short shrift to the Amedisys "Being Mortal" public information campaign, suggesting it amounts to simply owing the rights to a "single video" about general end of life care that is not "not necessarily" related to hospice. While the Amedisys program and campaign was inspired by and includes the groundbreaking documentary featuring Dr. Atul Gawande, what is most important is how Amedisys uses this documentary within a larger program in the communities in which it works in order to help generate difficult but necessary conversations about end of life care. Amedisys worked directly with PBS to secure the necessary rights to share and distribute this video with the public without restrictions. With those rights, it was able to provide an education grant to Antidote Education Company to provide CME/CE credit to physicians, PAs, NPs, nurses, and social workers, as part of our effort to reach

the broadest cross-section of healthcare professionals possible. (See Exhibit 1 for the Accreditation Summary) The first Being Mortal workshop took place in August 2015. To date, Amedisys and affiliates have hosted over 350 events for health care providers, and issued over 2,860 credits nationally.

The most valuable part of the Being Mortal Workshop is the interactive discussion led by an Amedisys hospice specialist after the film. The discussion focuses on having more effective and successful conversations with patients and family facing a serious or life-limiting illness. After the workshop, Amedisys follows up with the attendees and provides them with a Crucial Conversation Toolkit which includes resources to support them in having these important advance care planning conversations (especially those associated with a terminal illness). This interactive discussion and toolkit make its Being Mortal program unique.

The State Health Plan standard requires documentation of plans for public education programs designed to increase awareness and consciousness of the needs of dying individuals and their caregivers. The Being Mortal program is squarely within this requirement.

The suggestion that promoting more effective and successful conversations with patients and families facing a serious or life-limiting illness is "not necessarily" related to hospice care is surprising coming from a hospice program. These conversations are a necessary predicate to a conversation about hospice. Each Being Mortal program generates a wealth of in-depth end of life conversations, and it is these conversations that uncover the need for hospice care. Belying MH's suggestion that there is no necessary relationship between end of life conversations and hospice care, the Hospice Foundation of America sponsored and coordinated a public awareness campaign involving organized screenings of the Being Mortal documentary, a campaign that

commenced in January, 2016 and runs through the end of June 2017. See Exhibit 2 HFA's Chairman of the Board of Directors is quoted in the press release saying that: "Anyone who has seen 'Being Mortal' knows the important message it sends about end-of-life discussions and awareness."[2]

Moreover, Amedisys' experience is that its Being Mortal program is very effective in increasing the utilization of hospice. Amedisys launched the Being Mortal campaign in its existing jurisdictions in Maryland in November 2016, when it hosted 9 events in Rosedale and Elkton. (See Exhibit 3 for an invitation to one of these events.) The direct result of these community programs has been a 35% increase in referrals to Amedisys, an increase that has been sustained since those events. Amedisys believes that its Being Mortal program will be similarly effective in Prince George's County, particularly among communities that have underutilized hospice services up until now.

MH misses the point of Amedisys' reference to the translation of the Being Mortal program and written materials into Cantonese by the Amedisys affiliate in Boston at page 24 of its Application. This demonstrates that Amedisys tailors its public education campaigns to the community it is serving. MH suggests that Amedisys' plan to hire outreach staff from within Prince George's County is insufficient, but for no reason other than that Amedisys has not already hired such a person in advance of being awarded a CON. There is no requirement that an applicant have started hiring staff in order to be granted a CON.[3] In Amedisys' experience, it will be able to hire necessary outreach staff in Prince George's County promptly after obtaining a CON, who will assist in implementing public education efforts immediately.

[2] HFA's campaign is independent of the Amedisys program that also uses the "Being Mortal" documentary.
[3] Because Prince George's County is a non-contiguous county to those currently served by Amedisys, it cannot hire staff now on the assumption that, if it is not awarded a CON, it can simply use that staff in a contiguous county.

Amedisys has far more experience in starting up new hospice programs than MH, which has one program that started up 35 years ago. Amedisys started up 131 new programs in the last ten years (including 19 hospice start-ups).

There are a variety of other ways that Amedisys described in its Application to reach communities that have historically underutilized hospice services that were ignored by MH in its comments. As described on page 24 of the Application, these include strong community marketing to church congregations, speaking to local womens' groups, social service and missionary groups, recruiting volunteers from within the community, providing activities and services at local community and senior centers, and co-marketing with meals on wheels. Further, Amedisys explained that it would invite senior services agencies into its office to provide education to the Amedisys staff and partner with them to assess need and provide education to their customers.

Additionally, as described in its Application, Amedisys is a partner in the We Honor Veterans (WHV) program of the National Hospice and Palliative Care Organization (NHPCO), a program focused on increasing access to end of life care for Veterans, an underserved population. The WHV Program provides education, resources and technical assistance to educate hospice professionals caring for Veterans, including those whose military service, combat experience or other traumatic events may come to light during their dying process. According to the NHCPO, "a vast majority of Veterans are not enrolled in VA and may not be aware of end-of-life services and benefits available to them, including the Medicare Hospice Benefit and VA-paid hospice care." See Exhibit 4.

Accordingly, a core goal of the WHV program is to "increase access to hospice and palliative care for Veterans in their community," and a core part of the program is Veteran-specific community education. The unique needs of Veterans requiring specialized outreach and education are summarized on the WHV program website (www.wehonorveterans.org) as follows: "All wars are different and provide unique experiences and sometimes complications to the veterans who served in them"; "too many of our nation's Veterans live with complicating factors such as homelessness, substance abuse, PTSD and more" requiring education about "special populations of Veterans that are underserved or at high risk."

While any hospice program may (and hospices are encouraged to) become a partner in the WHV program, programs are distinguished by the number of stars (1-4) they earn from NHPCO through demonstrated achievement in various areas, including community education and staff and volunteer training in the unique needs of the veteran population. See Exhibit 4. Amedisys requires all of its hospice programs to partner in WHV and to achieve 4 stars; the existing Amedisys Maryland hospice programs have earned 4 stars as would the new program in Prince George's County.[4]

The WHV Program is particularly relevant to Prince George's County, which has largest Veteran population of all jurisdictions in Maryland, with nearly 60,000 Veteran residents according to the Maryland Department of Planning. See Exhibit 5. Further, the Veteran population is aging, making the need for a Veteran-specific public education campaign about hospice care all the more important. While County-specific data on age of Veterans is not available, 41% of Veterans in Maryland are aged 65 and older according the Department of

[4] The WPV Provider Directory containing the stars achieved by each partner is found at https://www.wehonorveterans.org/partner-directory. MH is a partner is the WHV program, but has achieved one star.

Veterans Affairs.[5] See Exhibit 6. According to the NHPCO, of the 2.4 million deaths in the United States each year, approximately 680,000 are Veterans. See Exhibit 4. As the NHPCO further explains on its WPV website, "[t]o put this in perspective, there are more Veterans anticipated to die each year for the next decade than died in all of World War II. With the aging of the World War II-, Korean- and Vietnam-era Veterans, an increasing number will require end-of-life care...."

As a 4-star WHV program, Amedisys is uniquely well-positioned to undertake outreach and education about hospice care within the large veteran population in Prince George's County. As it does in its existing jurisdictions, Amedisys' highly trained staff will conduct Veteran-specific educational presentations in its communities at Veteran-organization venues such as VFW and American Legion halls, as well as at community and health care venues. See Exhibit 6 for a flyer about the Amedisys WHV program.[6]

Additionally, in its outreach to communities that have historically underutilized hospice, Amedisys leverages its open access philosophy that not all hospice programs share, meaning that it does not require the patient to give up on hope in order to be admitted to the program. This program is called "Power Of Yes!" This Amedisys philosophy supports patients to continue current treatments, especially those focused on improving quality of life. This includes, among other things, artificial nutrition and blood transfusions. Also, Amedisys never requires a patient to have a "Do Not Resuscitate" (DNR) order in place before Amedisys will admit the patient. Some underutilization of hospice is due to a reluctance to give up hope, or to give up current

[5] The VA data also shows that 41% of Veterans living in Maryland are African-American (see Exhibit 6), a population that underutilizes hospice services as well.

[6] Amedisys staff are also trained to conduct assessments of Veterans to identify health issues associated with military service, benefits to which the Veteran may be entitled, impact of military service on the Veteran and family members, and establish goals of care that honor the Veteran's preferences.

treatment or to execute a DNR, but these are not preconditions to hospice care with Amedisys. See Exhibit 8.

Finally, Amedisys' public education campaign will also include its "Is Hospice the Answer" quiz, which has proven to be a significant tool for community outreach for educating on hospice and bringing care to underserved populations. The questionnaire (see Exhibit 9) is made available in print and on the Amedisys website. An average of 317 people filled out the questionnaire per month over the last 12 months, and this is growing at a rate of 10% a month. When a questionnaire is completed, the person is immediately contacted by an Amedisys representative to follow up.

3. Viability

a. Community Support

MH suggests that Amedisys is required to produce letters of support from community leaders in order to demonstrate viability under COMAR 10.24.01.08G(3)(d). This is incorrect. The viability standard states that the Commission will consider "financial and non-financial resources, including community support, necessary to implement the project." This does not require letters from community leaders; rather, it allows letters of community support to be considered as a non-financial resource necessary to implement the project, if the applicant is relying on such community leaders. As described in its Application, Amedisys has an affiliate that provides home health agency services in Prince George's County that has established relationships with other health care providers and facilities in Prince George's County that will benefit Amedisys in establishing a hospice program in that County. Additionally, as reflected in its response to the first set of completeness questions, Amedisys' has already started making

linkages with other health care providers and facilities in Prince George's County. See Exhibit 11 for support letters from referral sources in Amedisys' existing jurisdictions.

b. Legal Proceedings

MH suggests that certain pending legal proceedings and a 2014 settlement with the Department of Justice ("DOJ") disclosed by Amedisys raise concerns about the resources available to support the project. There is no basis for such a concern. As shown in Application Table 4, the program is projected to have an operating loss of $461,210 in its first year of operation, and to be profitable beginning in its second year of operation. The Applicant's parent company, Amedisys, Inc., reported total liquidity of $218 Million as of the first quarter of 2017 (see Exhibit 10, at p. 15), clearly sufficient to cover the projected loss from this project in the first year. This level of liquidity exists three years after the settlement with the DOJ was consummated,[7] and after the wage and hour litigation and the commercial litigation highlighted by MH in its comments were settled in 2016. Additionally, Amedisys announced the settlement of the securities litigation referenced by MH on June 12, 2017. This shareholder litigation, commenced in 2010, was based on the same allegations that were the subject of the 2014 settlement with DOJ. Under the settlement, Amedisys agreed to pay $43.8 million, of which $15 million will be paid by insurance and the remainder from internal cash reserves.[8] Accordingly, there is no basis for any concern over the availability of resources to support this project.

[7]Amedisys, Inc. entered into the settlement with the DOJ without any admission of liability and as a matter of convenience in order to avoid the continued cost of defending the case and to avoid the uncertainty of litigation.
[8]Like the DOJ settlement Amedisys settled the securities litigation without any admission of liability in order to eliminate the uncertainties, risk, distraction and expense associated with this protracted litigation,

c. Working Capital

MH suggests that the proposed Amedisys program is not viable because it does not have a sufficient amount of working capital. MH's only support for this claim is its purported experience that working capital startup costs are necessary to initiate general hospice services in a new geographic area. MH operates one program in one county, a program that commenced operations (according to MH's application) 35 years ago. MH is not in a position to offer any relevant experience on what is required to start up a hospice program in a new jurisdiction in 2017.

In contrast, Amedisys has extensive, recent experience in starting up hospice programs in new jurisdictions. Amedisys started up 131 new programs in the last ten years (including 19 hospice start-ups). Based on its relevant experience, Amedysis considers the expansion of its operations to serve Prince George's County residents to be no different than expanding its existing operations in the four Counties it currently provides services. Amedisys has sufficient capital to cover operating losses for this proposed expansion. See Exhibit 10, at p. 15 (Amedisys Inc.'s total liquidity as of first quarter of 2017 is $218 Million). Amedisys intends to expense losses in the year in which they occur, (in other words, does not intend to capitalize those expenses over a longer period of time, as would be the case if there were significant capital expenditures needed to finance this expansion), and therefore did not include them in the project budget as a working capital.

d. Cost of Care

MH claims that Amedisys has lower costs of care and longer average discharge lengths of stay as compared to the Medicare average, from which it suggests two "inferences" may be

drawn: that Amedisys "may be" selecting patients based on cost, and that Amedisys "may be" limiting services customarily provided under the Medicare hospice benefit." Both inferences are completely unfounded and based on pure speculation by MH, thus do not provide a basis to conclude that Amedisys has not satisfied the State Health Plan standard. Nor has MH explained how having lower costs of care and/or a longer average length of stay calls into question the viability of the program.

Amedisys is a scaled, national platform that achieves operational efficiencies and effectiveness while maintaining clinical distinction and attracting top clinical talent for its local operations. It takes advantage of its pricing power due to its national footprint to leverage its negotiating position with suppliers to drive costs down. It has nothing whatsoever to do with to do with the level of patient care or their ability to pay. Costs are costs, and the statistics are driven by costs in the numerator and visits in the denominator.

Further, the longer average length of stay demonstrates Amedisys' success in working with multiple referral sources and educating health care providers and patients earlier in the dying process to utilize hospice care as soon as it is appropriate. Every day of life matters, and Amedisys views hospice services as a means for allowing people to make the very most of their time, even when faced with life-limiting circumstances. A longer length of time in hospice care means that patients and their loved ones are able to maximize their experience of the emotional, psychological and spiritual support under expert medical guidance that Amedisys provides.

4. Pediatric Patients

MH incorrectly claims that Amedisys has not satisfied COMAR 10.24.13.05B because it will not admit pediatric patients. This standard requires the applicant to identify its admission

criteria and proposed limits by age, disease or caregiver, a requirement with which Amedisys clearly complied. It does not prohibit admission limitations based on age. To the contrary, it contemplates that applicants will have differing admission criteria as to age, disease or caregiver, rejecting a one-size fits all approach and allowing applicants to propose different admission criteria based on their care models.

Pediatric patients make up a small percentage of hospice patients. According to the Commission's public use data set, only 15 out of 1,826 hospice patients in Prince George's County (0.82%) in 2015 were ages 0-24. Amedisys will admit only adult patients (over the age of 18), but it will coordinate with other providers to ensure that the best setting of care is found for a pediatric patient.

Further, Amedisys has proposed to meet only a portion of the need projection, allowing the Commission to approve additional programs. This is in contrast to MH, which seeks to foreclose the approval of other new hospice programs in Prince George's County by proposing to meet all or nearly all of the projected need in 2019.

RESPONSE TO BAYADA COMMENTS

1. The Corporate Integrity Agreement

Bayada argues it should be approved over Amedisys in a comparative review because Amedisys is subject to a Corporate Integrity Agreement ("CIA"). It recites the allegations in the underlying case as if they were established as facts, and argues that the Commission should select Bayada over Amedisys because it does not have this "track record." Amedisys has no such "track record" so it is not a basis upon which to compare the applications of Amedisys and

Bayada.[9] These were unproven allegations in a case that Amedisys decided to settle – without any admission of liability -- as a matter of convenience simply to avoid the continued expense and uncertainty of litigation. The CIA that Amedisys agreed to as part of the settlement formalized various aspects of its already-existing ethics and compliance programs. Amedisys also agreed to other requirements designed to help ensure its ongoing compliance with federal health care program requirements. If anything, the fact that Amedisys is subject to the CIA provides the Commission greater assurance of regulatory compliance than it would have in the absence of a CIA.

2. Community Outreach Staff

Bayada also claims that Amedisys provided misleading information about the employment of Mr. Clash. Mr. Clash had accepted employment with Amedisys as of the time its CON application was filed and he was scheduled to start. Amedisys considered Mr. Clash to be committed but he changed his mind at the last minute, after the CON application was filed. The fact that Mr. Clash unexpectedly changed his mind, however, is immaterial. He was hired for Baltimore City, not Prince George's County. This example still serves as an example of Amedisys' practice of seeking to hire "embedded" staff from within communities it serves to strengthen its outreach and education efforts.

In fact, within 30 days after Mr. Clash informed Amedisys that he had changed his mind, Amedisys had recruited another well-qualified, embedded community member in Baltimore City to perform exactly the community outreach functions for which Mr. Clash had been hired. As

[99] Bayada does not point to any particular State Health Plan standard or review criteria that it alleges Amedisys has not satisfied or upon which it should be compared favorably to Amedisys because Amedisys agreed to a CIA.

Amedysis stated in its Application (at p. 24), it plans to provide expanded education and outreach in Prince George's County through similarly embedded and qualified staff.

3. Public Education and Outreach Programs

Bayada also claims that Amedisys has supplied misleading information about the Being Mortal program. It is Bayada, however, that has provided inaccurate and misleading information about this program in characterizing the Being Mortal program is a program of the Hospice Foundation of America (HFA) and suggesting that anyone can get the same rights as Amedisys to the "Being Mortal" documentary by completing a 15-minute Survey Monkey application. HFA sponsored and coordinated its own public awareness campaign involving organized screenings of the Being Mortal documentary. The HFA's campaign is a time-limited campaign (that commenced in January, 2016 and runs through the end of June 2017) in which HFA accepts applications to screen the Being Mortal documentary under HFA's rights.[10] See Exhibit 2.

Amedisys did not secure its rights to the Being Mortal documentary through HFA. As described above in the response to MH's comments, Amedisys directly owns the rights from PBS and has the unrestricted right to share and distribute this groundbreaking documentary featuring Dr. Atul Gawande video with the public. Nor is the Amedisys program the same as the HFA program. While the Amedisys program and campaign was inspired by and includes the Being Mortal documentary, what is most important is how Amedisys uses this documentary within a larger program in the communities in which it works in order to help generate difficult but necessary conversations about end of life care. The most valuable part of the Amedisys

[10] The program was initially scheduled to run through the end of 2016, but was extended through the end of June, 2017 according to the HFA website. https://hospicefoundation.org/Home/Being-Mortal-Project.

Being Mortal workshop is the unique interactive discussion led by an Amedisys hospice specialist after the film. The discussion focuses on having more effective and successful conversations with patients and family facing a serious or life-limiting illness. As also described above, with its ownership rights, it was able to provide an education grant to Antidote Education Company to provide CME/CE credit to physicians, PAs, NPs, nurses, and social workers, as part of our effort to reach the broadest cross-section of healthcare professionals possible. (See Exhibit 1 for the Accreditation Summary.) To date, Amedisys and affiliates have hosted over 350 events for health care providers, and issued over 2,860 credits nationally.

Bayada states that Amedisys has not demonstrated that the Being Mortal program will "uniquely help" to increase hospice awareness and acceptance in underserved communities in Prince George's County." It is unclear what "uniquely help" means, but it has no basis in the actual State Health Plan Standard, which requires an applicant to document its plan for public education programs designed to increase awareness and consciousness of the needs of dying individuals and their caregivers, to increase the provision of hospice services to minorities and the underserved, and to reduce the disparities in hospice utilization." The Being Mortal program is squarely within this requirement. Promoting more effective and successful conversations with patients and families facing a serious or life-limiting illness is crucial to overcoming psychological, religious, cultural and other barriers to utilizing hospice. Being Mortal program will be an important public education tool to increase hospice acceptance and utilization in Prince George's County, including within minorities and communities that have underutilized hospice services up until now.

Having itself pointed out that a leading national hospice organization (HFA) is sponsoring a public information campaign centered on the Being Mortal documentary, it is odd

that Bayada would, at the same time, suggest that this documentary bears no necessary relationship to public awareness of the benefits of hospice care. Conversations around the end of life issues addressed in the Being Mortal documentary are a necessary predicate to a conversation about hospice. Each Being Mortal program sponsored by Amedisys generates a wealth of in-depth end of life conversations, and it is these conversations that uncover the need for hospice care. As described above, after Amedisys launched the Being Mortal campaign in its existing jurisdictions in Maryland in November 2016 hosting 9 events in Rosedale and Elkton, Amedisys experienced a 35% increase in hospice referrals, an increase that has been sustained since those events

Bayada suggests that the public education campaign that Amedisys has proposed will focus only on "institutions" rather than including individuals as well. To the contrary, the Amedisys application describes a comprehensive public education campaign that includes both institutions and individuals. The Being Mortal program is heavily focused on educating individual health care practitioners; indeed, as described above, it provides continuing education credits to health care practitioners. As also described above, conducting Being Mortal programs with health care practitioners in Amedisys' existing jurisdictions resulted in a substantial increase in hospice utilization in those counties. Further, Amedisys described its plan to hire qualified embedded outreach and marketing staff in Prince George's County, who visit individual health care practitioners' offices on a daily basis to increase awareness and hospice utilization.

Additionally, as described in its Application and above in response to MH's comments, Amedisys is a four-star partner in the We Honor Veterans (WHV) program, a program focused

on increasing access to end of life care for Veterans, an underserved population.[11] As such, Amedisys is uniquely well-positioned to undertake outreach and education about hospice care amongst the Veteran population in Prince George's County, the largest such population in the State. As it does in its existing jurisdictions, Amedisys' highly trained staff will conduct Veteran-specific educational presentations to Veterans and their families at Veteran-organization venues such as VFW and American Legion halls in Prince George's County, as well as at community and health care venues.

4. Charity Care Policy

Finally, Bayada suggests that the Amedisys charity care policy is "complex and restrictive" by concocting an implausible (and inaccurate) interpretation of the policy. Contrary to Bayada's suggestion, the patient is not being requalified for charity care during the course of care after admission. The internal approvals are back office recordkeeping requirements; they do not involve the patient or the family in any way. The necessary information for eligibility for charity care is obtained from the patient or family up front, at admission. Once qualified, if the cost of care exceeds what was projected up-front, this does not impact ongoing care of the patient. For example, if upon admission a patient was expected to require between $1,000 and $5,000 of care (for which approval of the AVP was obtained), but the patient ends up needing in excess of $5,000 in care, then the local office simply obtains the specified approval from the corporate office or SVP at that time. This ensures appropriate recordkeeping internally, but is seamless to the patient and family. Amedisys has never discharged, and would not discharge, a

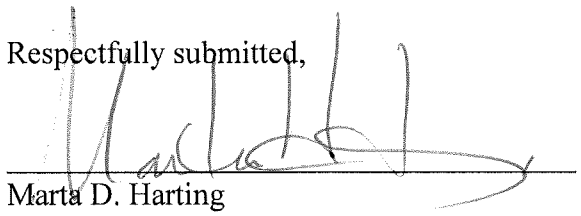
[11] Although Bayada has hospice programs in other states that are WHV partners, they have varying ratings (including new "recruits" with no rating, one star, three stars and four stars) and its Application to establish a program in Prince George's County is silent about the WHV program. See https://www.wehonorveterans.org/partner-directory.

charity care patient because costs exceeded what was originally expected requiring an additional internal approval.

CONCLUSION

For the reasons stated above and in the Amedisys CON application, the Amedisys CON Application should be approved.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that on this 21st of June, 2017, a copy of the foregoing Response to Interested Party Comments of Montgomery Hospice and Bayada Hospice was sent by electronic mail and by first class mail, postage prepaid, to:

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18169533-v1

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to Interested Party Comments of Bayada Hospice filed by Amedisys Hospice of Greater Chesapeake are true and correct to the best of my knowledge, information and belief.

Date: 6/21/17

Name: DAVID KWIATKOWSKI
Title: DIRECTOR

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to Interested Party Comments of Bayada Hospice filed by Amedisys Hospice of Greater Chesapeake are true and correct to the best of my knowledge, information and belief.

Date: 6/21/17

Name: Laura Scipio RN BHA CHPN
Title: Area Vice President Operations

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to Interested Party Comments of Bayada Hospice filed by Amedisys Hospice of Greater Chesapeake are true and correct to the best of my knowledge, information and belief.

Date: 6/21/2017

RT Coughlin

Name:

Title: Director, DHS Healthcare (consultant to Amedisys)

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to Interested Party Comments of Montgomery Hospice filed by Amedisys Hospice of Greater Chesapeake are true and correct to the best of my knowledge, information and belief.

Date: 6/21/2017

RJ Coyman

Name:

Title: DIRECTOR, DHG HEALTHCARE (Consultant to Amedisys)

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to Interested Party Comments of Bayada Hospice filed by Amedisys Hospice of Greater Chesapeake are true and correct to the best of my knowledge, information and belief.

Date:

Name:
Title:

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to Interested Party Comments of Bayada Hospice filed by Amedisys Hospice of Greater Chesapeake are true and correct to the best of my knowledge, information and belief.

Date: 6/21/17

Name: DAVID KWIATKOWSKI
Title: DIRECTOR

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to Interested Party Comments of Bayada Hospice filed by Amedisys Hospice of Greater Chesapeake are true and correct to the best of my knowledge, information and belief.

Date: 6/21/2017

RT Coughlin

Name:

Title: Director, DHG Healthcare (Consultant to Amedisys)

EXHIBIT 1

antidote
EDUCATION COMPANY

Being Mortal:
Conversations About the End of Life

Release Date: September 2, 2015
Expiration Date: September 2, 2017
Format: Internet-based Video

Target Audience
This program is designed for physicians, nurse practitioners, physician assistants, nurses and social workers and others involved in the care of patients nearing the end of their life.

Statement of Purpose
As was poignantly stated in the PBS Frontline special, "Doctors are often remarkably untrained, ill-suited and uncomfortable talking about chronic illness and death with their patients." For most physicians and their teams, there is little training in managing end-of-life and having these difficult conversations with patients and families. Medical school and residency training has imparted the belief that death is failure. Too often, death comes as a surprise to patients' loved ones because this conversation never took place. There is no natural time to have these conversations until a crisis comes, and too often it's too late. Also, sometimes what physicians do say to patients in not what patients hear, and their death comes as a surprise to family members. Patients have definite goals like to die at home or avoid suffering. However, too often physicians and their care teams do not ask their patients about their goals and fears, so treatment is not aligned with their patients' priorities.

This CME activity will discuss how healthcare professionals can better help terminally ill patients prepare for death, and provide training in effective ways to engage patients and families in these difficult conversations that can empower patients to live their lives fully. It will define the importance of patients' goals of care, and discuss ethical concerns of end-of-life decision-making.

Learning Objectives
Upon completion of this activity, you should be able to:

1. Explain the benefits of having conversations about your patients' goals of care and what's important to them
2. Use strategies and tools to aid in conversations with patients about their goals of care
3. Initiate conversations with your patients to learn their goals of care and what's important to them
4. Engage in difficult conversations about prognosis, treatment and location of care to understand a patient's priorities and goals of care
5. Recommend care plans for patients based on their goals of care

Presenting Faculty
Atul Gwande, MD, MPH Dr. Gawande is a surgeon, writer, and public health researcher. He practices general and endocrine surgery at Brigham and Women's Hospital. He is Professor in the Department of Health Policy and Management at the Harvard T.H. Chan School of Public Health and the Samuel O. Thier Professor of Surgery at Harvard Medical School. He is also Executive Director of Ariadne Labs, a joint center for health systems innovation, and Chairman of Lifebox, a nonprofit organization making surgery safer globally.

Dr. Gawande has been a staff writer for The New Yorker magazine since 1998 and has written four New York Times bestsellers: Complications, Better, The Checklist Manifesto, and most recently, Being Mortal: Medicine and What Matters in the End. He is the winner of two National Magazine Awards, Academy Health's Impact Award for highest research impact on healthcare, a MacArthur Fellowship, and the Lewis Thomas Award for writing about science.

Being Mortal:

Conversations About the End of Life

Content Planning Faculty

Michael Fleming, MD, FAAFP Dr. Fleming is chief medical officer of Antidote Education Company. He is a Clinical Associate Professor of Family Medicine at LSU Health Science Center in Shreveport, and Clinical Assistant Professor of Family and Community Medicine at Tulane University School of Medicine. Dr. Fleming has more than 29 years of medical field experience and is past President of the American Academy of Family Physicians and the Louisiana Academy of Family Physicians; and was founding President of the Louisiana Health Care Quality Forum.

Accreditation

AMA: This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint providership of Antidote Education Company and Amedisys. Antidote is accredited by the ACCME to provide continuing medical education for physicians.

Antidote Education Company designates this enduring activity for a maximum of 1.0 *AMA PRA Category 1 Credit*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

AAFP: This Enduring Material activity, Being Mortal: Conversations About the End of Life, has been reviewed and is acceptable for up to 1.00 Prescribed credit(s) by the American Academy of Family Physicians. Term of approval begins 09/01/2015. Term of approval is for one year from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AANP: This program is approved for 1.0 contact hour(s) of continuing education by the American Association of Nurse Practitioners. Program ID 1508338. This program was planned in accordance with AANP CE Standards and Policies.

NASW: This program is Approved by the National Association of Social Workers (Approval # 886592955-0) for 1 Social Work continuing education contact hours.

Method of Participation

- Register/Sign In
- Read the learning objectives and disclosures.
- View the entire video.
- Complete the evaluation and return it to your host.
- A certificate will be emailed to you within 2 weeks

Educational Grant

This CME activity is supported by an unrestricted educational grant from Amedisys.

Disclaimer:

The material presented at this course is being made available by Antidote Education Company for educational purposes only. This material is not intended to represent the only, nor necessarily best methods or procedures appropriate for the medical situations discussed, but rather is intended to present an approach, view, statement or opinion of the faculty which may be helpful to others who face similar situations. Opinions expressed in this activity are those of the faculty and not of Antidote or the joint sponsor. Every effort has been made to assure the accuracy of the data presented at this course. Physicians may care to check specific details such as drug doses and contraindications in standard sources prior to clinical application.

Disclosure

Antidote is committed to creating, developing, and operating high-quality, relevant, and practical continuing medical education activities that are in compliance with the ACCME's policies on commercial support and disclosure. Specifically, we are dedicated to ensuring that our events are planned and implemented free of the control of commercial interests and to identifying and resolving conflicts of interest of all persons in a position to control the content of an educational activity before the educational activity is delivered to our attendees. In addition, it is our standard practice to disclose all relevant financial relationships of our speakers in writing to our attendees before the beginning of an educational activity. **The content of this material does not relate to any product of a commercial interest; therefore, there are no relevant financial relationships to disclose.**

EXHIBIT 2

HOSPICE FOUNDATION
OF AMERICA

FOR IMMEDIATE RELEASE
January 19, 2016

Hospice Foundation of America to Organize
Public Awareness Campaign around Advance Care Planning
Grant from John and Wauna Harman Foundation to Fund Effort

The John and Wauna Harman Foundation (Harman Foundation) has selected Hospice Foundation of America (HFA) to sponsor and coordinate a public awareness campaign on the importance of talking about end-of-life preferences and goals with loved ones and medical professionals.

The project uses PBS's FRONTLINE film, "Being Mortal," to educate audiences and encourage people to take concrete steps to identify and communicate their wishes for end-of-life care. HFA will organize screenings of the documentary in communities nationwide to engage wide and diverse audiences, including both members of the public and clinicians, to spark reflection and discussion about the need for these sensitive conversations.

The screenings will be followed by a guided discussion. Screening Sites selected by HFA will be asked to partner with a community-based organization to increase community participation and ensure representation of *both* medical professionals and lay people. Screenings will begin later this year and continue through 2016.

Aired on PBS in February 2015, "Being Mortal" follows physician Atul Gawande as he thinks about death and dying in the context of being a healer. The renowned writer and Boston surgeon shares stories about experiences at the end of life from patients and his own family. Dr. Gawande published a national bestselling book by the same name. The Harman Foundation was an underwriter of the FRONTLINE film.

"While written advance care directives (ACDs) are important, the nuances of end-of-life care can't be captured in a checklist," said Julie Berrey, executive director of the Harman Foundation. "Discussing deeply-held personal values and what matters most at the end of life *before* a serious illness occurs helps make shared decision-making easier for patients and families when a loved one faces a severe illness, especially in the absence of formal ACDs or when a patient can no longer participate in the discussion."

Seventy percent of Americans say they would prefer to die at home, but nearly 70 percent die in hospitals and institutions. Ninety percent of Americans know they *should* have conversations about end-of-life care, yet only 30 percent have done so.

To help close this gap, the Harman Foundation and the California HealthCare Foundation collaborated in 2015 to promote viewing and discussion of "Being Mortal" by Californians through support of over 65 screenings in communities throughout the state. The effort was a huge success, with public interest far exceeding expectations and resulting in the decision to expand the effort nationally.

"We're honored to partner with the Harman Foundation on this important national project at the grassroots level," said Thomas J. Spulak, chairman of HFA's board of directors. "Anyone who has seen 'Being Mortal' knows the important message it sends about end-of-life discussions and awareness. HFA's experience in community-based education will enable it to fully support local screening sites to hold engaging community events."

For more information contact Amy Tucci, HFA, atucci@hospicefoundation.org or 1-800-854-3402.

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About the John and Wauna Harman Foundation
The John and Wauna Harman Foundation (Harman Foundation) is a private family foundation rooted in its donors' humble beginnings. Thus, the Harman Foundation values humility, compassion, education, and a concern for the most vulnerable in our society. Its mission is to improve end-of-life care in America by encouraging all Americans to have meaningful conversations with family and loved ones about their end-of-life care wishes *before* serious illness occurs, thereby improving quality of life as death is near.

About HFA
Hospice Foundation of America is a 501(c)(3) nonprofit organization. HFA meets its mission by providing programs for professional development, public education and information; funding research, producing publications, and by providing information on issues related to hospice and end-of-life care. Our programs for healthcare professionals are designed to improve care of those with terminal illness and those experiencing the process of grief, and are offered on a national basis. Our programs for the public are designed to assist individual consumers of health care who are coping with issues of caregiving, terminal illness, and grief.

EXHIBIT 3

A Special Invitation for Our Healthcare Partners

"I learned how to fix things.
But not how to manage the problems I could not fix."
— Atul Gawande, MD, "Being Mortal"

Join our hospice specialists for a review of
Dr. Gawande's groundbreaking documentary, "Being Mortal."
This workshop will feature an interactive discussion on having more effective and successful conversations with patients and families facing a serious or life-limiting illness.

"BEING MORTAL"

IMPROVING OUR COMFORT WITH DIFFICULT PATIENT CONVERSATIONS

A Special Screening & Conversation about the Groundbreaking Film

Wednesday, Nov. 9 & Thursday, Nov. 10

6:30 - 8:30 pm

VA Maryland Health Care System Loch Raven Campus
Rehabilitation Bldg. 1st Floor Multipurpose Room
3900 Loch Raven Boulevard

Free Parking
Refreshments will be served.
Email RSVP to **Linda.Kurlander@amedisys.com**
Be sure to include the date you plan to attend.
CME/CE credit for physicians, NPs, PAs, nurses and social workers.

To learn more, visit
www.Amedisys.com/BeingMortalCME

Accredited by Antidote Education Company *AMA PRA Category I Credit*™ Approved – AANP Approved

EXHIBIT 4

WE HONOR VETERANS

National Hospice and Palliative Care Organization

We Honor Veterans Campaign Fact Sheet

WHAT: We Honor Veterans (www.WeHonorVeterans.org) is a national hospice provider awareness campaign conducted by the National Hospice and Palliative Care Organization (NHPCO) in collaboration with the Department of Veterans Affairs (VA). NHPCO is actively supporting the campaign and providing resources for hospices to participate because:

- Of 2.4 million deaths in the United States each year, approximately 680,000 are Veterans
- A vast majority of Veterans are not enrolled in VA and may not be aware of end-of-life services and benefits available to them, including the Medicare Hospice Benefit and VA-paid hospice care
- Community hospices can join other hospice providers across the country in honoring our Nation's Veterans and be listed on the ***We Honor Veterans*** website

WHY: Hospices will have the ability to promote their level of commitment to Veterans by displaying the ***We Honor Veterans*** logo on their websites as well as community outreach and educational materials. By becoming a ***We Honor Veterans*** Partner, hospices will be better prepared to:

- Build professional and organizational capacity to provide quality care for Veterans
- Develop and/or strengthen partnerships with VA and other Veteran organizations
- Increase access to hospice and palliative care for Veterans living in their community
- Network with other hospices across the country to learn about best practice models

HOW: Hospices can join the ***We Honor Veterans*** campaign by signing and submitting the Partner Commitment form, found at www.WeHonor.Veteran.org. Hospices can "earn their stars" and matching logo by completing activities for each of the four levels of commitment. This allows VA staff and Veterans to easily identify hospices that have made a commitment to offer veteran-specific care and services provided by a competent and highly skilled workforce.

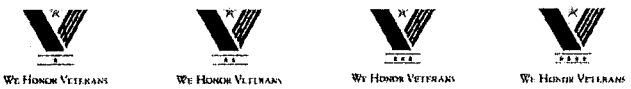
Recruit Get oriented and commit to the ***We Honor Veterans*** program

Level 1 Provide Veteran-centric education for staff and volunteers, and identify patients with military experience (1 Star: ***We Honor Veterans*** Level 1 logo)

Level 2 Build organizational capacity to provide quality care for Veterans (2 Stars: ***We Honor Veterans*** Level 2 logo)

Level 3 Develop and strengthen relationships with VA medical centers and other Veteran organizations (3 Stars: ***We Honor Veterans*** Level 3 logo)

Level 4 Increase access and improve quality of care for Veterans in your community (4 Stars: ***We Honor Veterans*** Level 4 logo)



RESOURCES: www.WeHonorVeterans.org provides community hospices, state hospice organizations, Hospice Veteran Partnerships and VA programs with tools and resources that encourage them to:

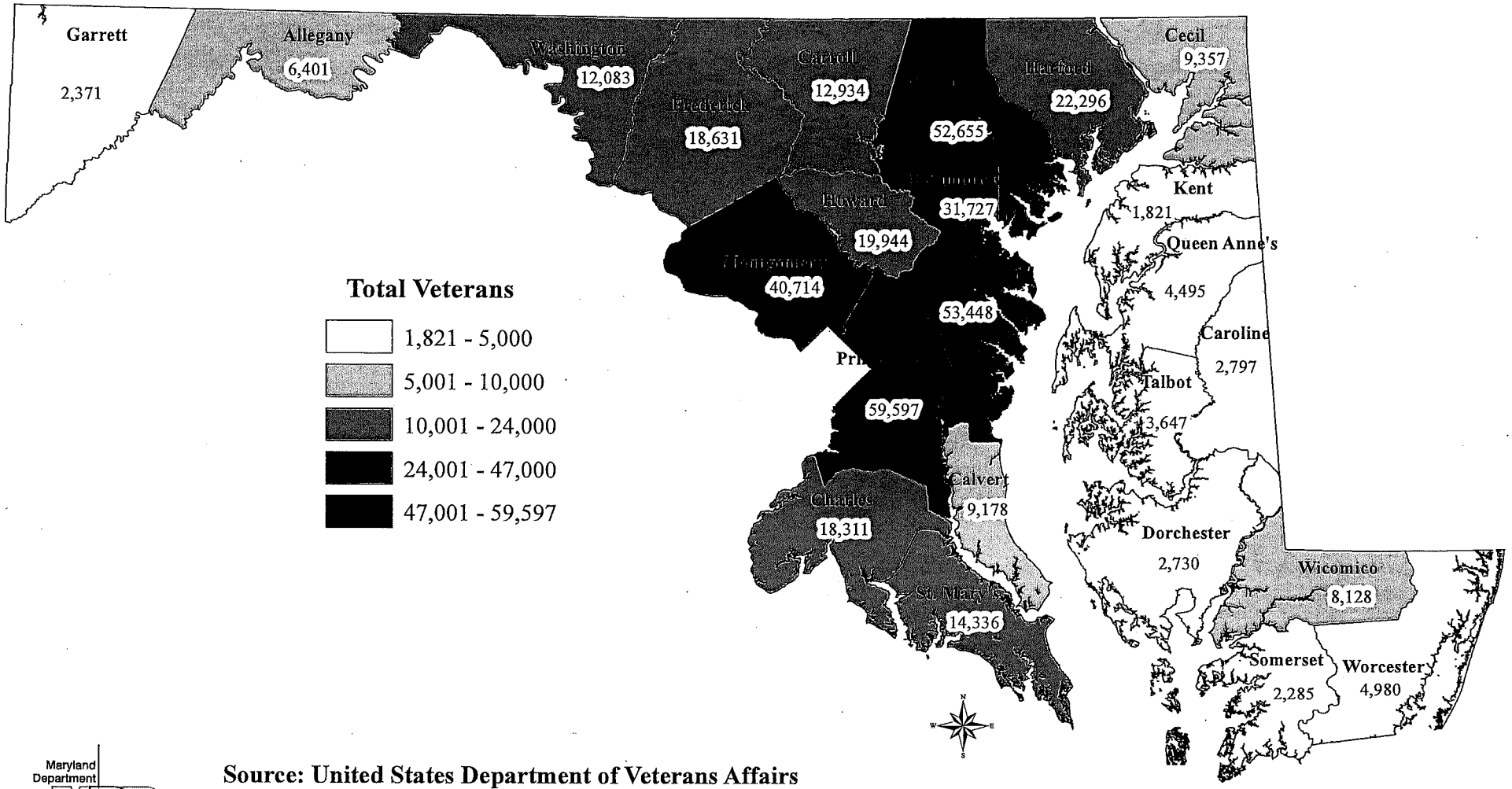
- Commit to honoring Veterans at the end of life
- Assess their current ability to serve Veterans
- Learn more about caring for Veterans
- Find resources to support Veterans at the end of life
- Provide veteran-centric education for staff
- Measure Quality and Outcomes

CONTACT: veterans@nhpco.org

EXHIBIT 5

Projected Number of Veterans in Maryland - 2017

Projected Veterans in Maryland: 414,879



Maryland Department of Planning

Source: United States Department of Veterans Affairs
Map prepared for the Maryland Department of Veterans Affairs
by the Maryland Department of Planning

EXHIBIT 6

Table 6L: VETPOP2016 LIVING VETERANS BY STATE, AGE GROUP, GENDER, 2015-2045

Date	9/30/2015
Gender	(All)

Numbers from this table should be reported to the nearest 1,000.

Veterans	Age Group															
State	< 20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+	Grand Total
Alabama	273	5,426	13,697	17,583	18,195	21,236	28,410	33,071	38,951	39,855	52,582	36,822	25,563	23,885	21,760	377,310
Alaska	26	1,533	4,177	5,120	4,582	4,660	5,766	6,826	7,587	7,487	8,131	5,954	2,518	1,888	1,754	68,008
Arizona	211	5,904	17,164	22,901	22,785	25,071	32,682	38,545	44,632	46,048	74,317	60,778	47,287	40,866	42,996	522,188
Arkansas	165	3,908	8,372	10,427	10,377	11,973	16,001	17,916	21,596	23,358	32,141	23,963	17,989	14,513	15,140	227,840
California	923	24,255	70,739	91,952	86,344	82,225	104,845	128,162	155,677	164,102	247,103	189,679	136,722	136,907	170,227	1,789,862
Colorado	256	5,979	17,477	23,048	22,257	25,077	33,157	36,075	39,862	39,828	55,740	37,723	26,819	22,809	25,575	411,683
Connecticut	115	2,191	5,803	7,386	7,352	7,596	10,617	14,554	17,988	16,104	28,245	21,746	16,549	18,098	24,818	199,163
Delaware	15	763	2,105	2,761	2,840	3,151	4,702	6,481	7,306	6,564	11,590	9,358	5,887	4,990	5,249	73,760
District of Columbia	11	245	789	1,733	1,968	1,627	2,106	2,517	3,177	2,965	2,954	2,250	1,790	1,944	2,898	28,977
Florida	593	15,289	45,680	61,504	63,625	73,307	98,805	126,585	146,187	135,862	220,093	178,838	139,175	134,890	153,785	1,594,218
Georgia	436	11,152	28,950	36,004	37,505	44,598	61,999	71,210	76,476	68,673	92,890	63,629	40,998	34,154	32,138	700,814
Hawaii	54	2,080	5,466	7,063	6,302	5,508	6,953	8,437	10,276	9,711	16,526	11,669	7,068	6,633	9,641	113,385
Idaho	64	1,781	4,900	6,098	5,822	6,375	8,855	9,678	10,606	12,236	18,250	12,744	9,618	8,010	9,085	124,123
Illinois	472	9,562	22,968	30,865	28,980	31,501	44,328	50,166	55,531	56,632	102,403	71,815	49,218	51,904	59,623	665,968
Indiana	245	7,140	15,444	18,739	17,191	20,908	31,301	38,790	42,582	42,665	60,805	43,048	28,674	29,185	30,611	427,328
Iowa	258	3,883	7,668	9,291	8,409	9,265	13,755	16,264	17,056	19,432	31,655	22,276	17,781	18,754	20,965	216,713
Kansas	118	3,792	9,231	10,849	10,017	10,616	13,431	14,793	17,396	19,103	28,291	20,447	12,335	13,381	15,686	199,486
Kentucky	178	4,313	10,636	13,345	13,697	16,405	22,857	26,146	28,984	29,906	43,526	32,411	20,617	19,671	19,377	302,068
Louisiana	206	5,239	12,283	18,099	17,829	18,644	23,997	20,847	24,969	29,257	38,329	27,368	18,915	16,369	18,103	290,455
Maine	50	1,359	3,393	4,223	4,536	5,511	7,563	10,212	12,107	11,988	17,866	13,078	9,334	8,826	9,507	119,554
Maryland	189	4,305	12,399	20,013	22,215	23,943	32,366	41,386	44,581	38,554	52,811	37,123	25,267	24,092	29,278	408,522
Massachusetts	100	3,723	10,653	12,973	12,119	12,937	17,963	25,037	31,652	29,056	50,178	41,036	30,486	30,956	40,818	349,687
Michigan	364	6,542	17,910	21,919	21,087	28,057	43,592	53,108	56,083	57,935	102,495	71,290	45,313	47,175	54,630	627,500
Minnesota	136	4,731	11,455	14,027	12,189	12,906	20,629	25,278	30,586	33,171	54,656	39,469	27,468	28,161	32,413	347,277
Mississippi	121	3,914	8,404	10,207	10,154	11,069	15,181	16,501	19,320	19,260	24,811	18,375	14,276	11,928	12,109	195,629
Missouri	322	6,304	15,940	19,993	19,762	22,124	30,616	37,290	43,812	44,289	68,216	47,477	33,720	32,657	36,182	458,702
Montana	63	1,367	3,661	4,763	4,507	4,687	6,099	6,796	7,633	9,050	13,787	10,964	7,062	6,460	6,457	93,356
Nebraska	106	2,141	5,449	7,045	6,278	6,861	9,695	10,852	11,592	12,084	18,753	12,881	10,332	10,452	11,371	135,893
Nevada	186	3,038	7,766	10,571	10,621	11,463	15,247	18,872	21,102	22,134	33,311	26,706	17,615	14,131	12,651	225,414
New Hampshire	47	1,304	3,209	3,874	3,864	4,850	6,706	9,450	11,775	10,471	16,188	13,013	8,968	7,989	9,163	110,873
New Jersey	129	4,187	10,867	14,912	14,877	14,539	19,831	27,434	33,086	29,662	56,274	42,780	35,140	37,422	46,705	387,844
New Mexico	63	1,903	5,019	7,216	7,475	7,863	10,603	12,992	15,611	16,756	24,200	18,245	12,433	11,433	11,741	163,554
New York	449	9,457	25,536	35,333	34,607	33,909	48,451	65,274	75,699	68,684	118,787	88,668	70,435	72,451	90,388	838,129
North Carolina	397	12,185	32,521	38,437	37,324	43,987	57,075	64,571	71,074	69,886	100,172	71,168	48,401	43,119	40,925	731,241
North Dakota	34	1,161	2,745	3,499	2,839	2,721	3,773	3,883	4,432	5,119	7,230	4,669	3,389	3,261	3,616	52,371
Ohio	397	10,057	26,177	32,570	32,004	40,112	58,909	69,646	77,603	77,473	121,703	85,408	58,344	58,395	69,043	817,840
Oklahoma	248	5,198	12,574	17,572	16,899	17,762	21,318	22,021	27,660	31,093	43,710	32,753	21,058	18,832	20,030	308,729
Oregon	121	3,144	9,614	12,960	12,673	14,348	19,669	22,661	26,944	32,383	50,634	38,837	23,735	21,413	27,845	316,982
Pennsylvania	355	9,854	24,901	32,320	32,263	36,212	54,172	66,632	74,944	74,156	132,095	100,094	70,423	74,596	89,285	872,301
Rhode Island	46	885	2,223	2,454	2,578	2,621	3,647	5,262	6,289	5,536	10,307	8,347	4,908	5,724	6,915	67,741
South Carolina	518	7,077	15,449	18,879	19,652	22,613	28,763	34,809	38,238	37,661	61,409	44,452	28,769	23,542	22,987	404,818
South Dakota	47	1,233	2,787	3,680	3,366	3,336	4,665	5,314	6,046	6,547	9,315	6,202	4,411	4,451	5,007	66,406
Tennessee	278	6,726	17,749	21,462	20,978	25,564	36,170	41,467	47,221	48,731	71,029	49,576	33,560	28,660	29,428	478,599
Texas	1,195	26,637	75,474	103,899	101,851	107,209	129,565	127,773	146,305	154,422	202,246	145,029	96,703	89,993	95,028	1,603,328
Utah	121	2,189	6,025	8,229	8,239	7,545	8,833	9,541	10,930	12,635	17,598	13,214	10,366	10,477	11,664	137,604
Vermont	16	527	1,318	1,564	1,576	1,907	2,820	3,873	4,835	4,547	6,490	4,829	3,632	3,353	4,072	45,360
Virginia	321	9,257	28,606	42,165	45,649	51,042	64,055	77,172	79,529	70,048	86,232	62,273	41,242	36,281	39,174	733,046
Washington	232	6,679	21,066	28,907	28,392	30,910	42,947	48,967	55,700	60,466	80,133	60,453	37,209	33,294	39,773	575,128
West Virginia	66	1,825	4,478	6,013	6,951	8,092	10,297	10,921	11,880	14,116	22,078	16,994	12,222	10,798	11,139	147,869
Wisconsin	225	5,263	12,707	15,567	13,316	15,336	25,208	29,829	34,067	35,748	57,348	43,412	31,595	30,211	33,568	383,399
Wyoming	34	808	2,106	2,795	2,680	2,763	3,517	3,653	4,060	4,980	7,123	5,026	2,860	2,724	2,557	47,686
Puerto Rico	28	1,067	2,052	2,509	2,776	2,665	2,958	4,415	7,000	7,829	11,434	10,879	10,228	10,730	9,335	85,905
Island Areas & Foreign	28	749	2,123	4,164	5,845	7,097	10,619	13,774	13,056	10,869	11,616	10,443	8,692	5,842	7,002	111,919
Grand Total	11,647	281,233	747,907	981,483	968,221	1,064,307	1,438,091	1,693,728	1,929,290	1,937,123	2,927,808	2,167,682	1,525,117	1,458,679	1,651,239	20,783,555

Predictive Analytics and Actuary, Office of Enterprise Integration
Department of Veterans Affairs
June 2017

Table 8L: VETPOP2016 LIVING VETERANS BY STATE, RACE/ETHNICITY, GENDER, 2015-2045

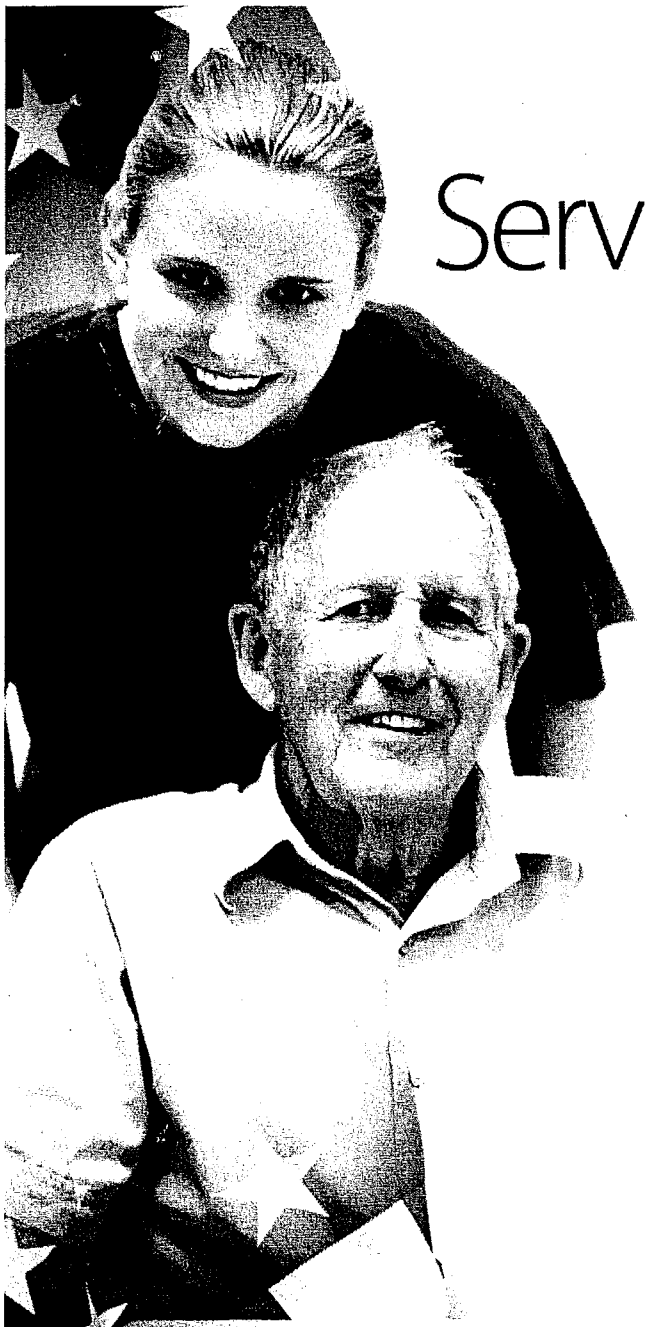
Date	9/30/2015
Gender	(All)

Numbers from this table should be reported to the nearest 1,000.

Veterans	Race/Ethnicity									
State	All Veterans	White, alone	Black or African American, alone	American Indian and Alaska Native, alone	Asian, alone	Native Hawaiian and Other Pacific Islander, alone	Some other race, alone	Two or more races	Hispanic or Latino (of any race)	White alone, Not Hispanic or Latino
Alabama	377,310	279,048	88,012	2,422	1,527	221	959	5,122	5,310	275,148
Alaska	68,008	53,565	3,996	4,536	1,420	304	874	3,313	3,566	50,862
Arizona	522,188	460,025	24,812	10,602	6,694	457	11,461	8,137	61,394	414,135
Arkansas	227,840	191,930	28,444	1,310	829	198	1,366	3,763	4,600	189,747
California	1,789,862	1,353,358	167,656	12,769	115,752	7,785	73,715	58,827	288,545	1,160,899
Colorado	411,683	361,125	24,071	3,319	4,228	690	7,992	10,257	41,864	331,247
Connecticut	199,163	175,499	14,296	843	873	2	4,934	2,716	13,588	167,820
Delaware	73,760	57,796	12,981	447	541	9	790	1,197	3,664	55,679
District of Columbia	28,977	10,876	16,228	6	504	3	341	1,019	1,301	10,532
Florida	1,594,218	1,356,254	180,315	5,758	13,970	879	14,099	22,943	135,454	1,246,397
Georgia	700,814	451,484	222,247	2,664	6,356	680	5,882	11,502	24,559	435,559
Hawaii	113,385	45,057	6,173	479	34,667	7,337	1,882	17,791	8,468	41,170
Idaho	124,123	118,227	512	1,775	1,227	92	905	1,385	4,264	115,071
Illinois	665,968	548,056	92,232	1,366	6,748	295	9,337	7,934	33,001	526,489
Indiana	427,328	378,741	37,266	1,564	1,039	28	2,190	6,500	10,165	371,454
Iowa	216,713	208,521	4,503	843	485	104	242	2,016	3,834	205,337
Kansas	199,486	179,859	11,353	1,557	1,380	306	1,176	3,855	8,597	173,697
Kentucky	302,068	268,194	27,786	931	1,053	459	318	3,327	5,292	264,211
Louisiana	290,455	205,478	76,872	1,454	1,239	102	1,814	3,497	7,643	200,174
Maine	119,554	115,358	1,108	780	226	137	53	1,892	950	114,859
Maryland	408,522	261,522	124,934	1,011	8,225	678	3,148	9,004	15,007	252,152
Massachusetts	349,687	324,927	12,574	541	3,800	261	2,836	4,748	10,459	317,812
Michigan	627,500	542,925	65,276	4,184	2,527	233	2,416	9,940	13,821	532,327
Minnesota	347,277	325,996	9,811	3,230	2,302	152	630	5,156	5,663	321,873
Mississippi	195,629	140,999	50,459	638	777	28	611	2,117	2,691	139,149
Missouri	458,702	403,795	40,922	2,218	2,196	327	1,412	7,832	8,379	397,567
Montana	93,356	86,464	511	3,089	837	0	366	2,090	2,239	84,994
Nebraska	135,893	127,480	5,534	357	466	16	715	1,324	4,456	123,969
Nevada	225,414	181,963	18,935	1,458	9,422	1,526	4,712	7,397	17,387	169,867
New Hampshire	110,873	105,899	1,372	356	543	5	865	1,833	2,215	104,840
New Jersey	387,844	313,447	52,143	797	7,079	108	7,210	7,059	28,912	295,697
New Mexico	163,554	133,404	5,328	10,147	1,330	42	9,719	3,583	49,326	96,532
New York	838,129	697,273	90,674	2,959	12,596	369	19,812	14,445	66,892	658,852
North Carolina	731,241	545,491	157,923	6,564	4,279	444	6,140	10,400	25,696	528,220
North Dakota	52,371	48,706	728	1,447	289	38	88	1,075	1,054	47,873
Ohio	817,840	718,169	81,407	1,870	2,512	201	2,865	10,815	16,289	706,964
Oklahoma	308,729	252,508	22,610	14,625	859	206	2,755	15,165	9,927	246,225
Oregon	316,982	295,389	4,946	3,151	2,691	519	1,493	8,795	10,849	287,417
Pennsylvania	872,301	773,663	78,310	1,903	4,022	157	4,895	9,352	19,987	760,521
Rhode Island	67,741	61,953	3,311	176	467	4	757	1,073	1,991	60,755
South Carolina	404,818	299,278	95,898	807	1,638	11	2,048	5,138	7,957	294,383
South Dakota	66,406	60,963	434	2,937	280	2	89	1,701	1,007	60,353
Tennessee	478,599	399,564	65,031	2,706	2,003	551	1,387	7,357	7,732	393,347
Texas	1,603,328	1,286,413	222,130	8,199	13,255	2,984	38,239	32,109	300,875	1,038,653
Utah	137,604	128,077	1,709	1,135	2,110	497	1,361	2,715	7,416	122,925
Vermont	45,360	43,720	383	428	36	5	33	754	274	43,478
Virginia	733,046	536,655	155,220	2,192	13,147	477	8,223	17,132	36,058	513,085
Washington	575,128	496,952	31,385	6,102	15,852	3,430	4,379	17,028	24,435	480,094
West Virginia	147,869	139,126	4,920	549	356	3	515	2,398	1,723	137,812
Wisconsin	383,399	359,841	13,546	3,459	2,001	203	1,311	3,039	9,200	352,771
Wyoming	47,686	45,649	772	734	17	3	317	194	2,054	44,062
Puerto Rico	85,905	62,199	9,061	247	23	0	10,071	4,305	84,325	1,109
Island Areas & Foreign	111,919	79,728	15,805	955	5,608	5,809	1,405	2,610	7,511	74,949
Grand Total	20,783,555	17,098,588	2,484,861	146,596	324,304	39,379	283,154	406,674	1,469,868	16,041,113

Predictive Analytics and Actuary, Office of Enterprise Integration
Department of Veterans Affairs
June 2017

EXHIBIT 7



Serving Our Veterans

Providing compassionate end-of-life care for those who served our country

Veterans have made many sacrifices over the course of their lives to protect and serve our country. And when it comes to the end of life, our goal is to protect the dignity and comfort of these service men and women.

That's why we are a We Honor Veterans partner, recognized by the National Hospice and Palliative Care Organization. Issues such as post-traumatic stress disorder, depression, and financial concerns can affect the end-of-life process for veterans and their families. Through our commitment to providing exceptional services for those who have served our country, our hospice specialists have completed **in-depth education and training** to meet veterans' unique physical and emotional needs at the end of life.

When your veteran patient comes on Amedisys Hospice Care, our specialists spend time learning about their life and experience in the military. By learning about his or her branch of service, time in combat and eligibility for VA benefits, we seek to provide care that fits your patient's individual needs so they can live **ALL the days of their lives with comfort and dignity.**

As a We Honor Veterans Partner, we offer many specializations in end-of-life care for veterans such as ***veteran-to-veteran volunteer programs, individualized salutes, honoring events and memorial ceremonies.***

To learn more about our Veteran's program or our hospice services, call us at:

XXX.XXX.XXXX

Amedisys®
Hospice Care

www.amedisys.com

FL-061-HSP REV 11/12

EXHIBIT 8

Your Care Needs Might Change

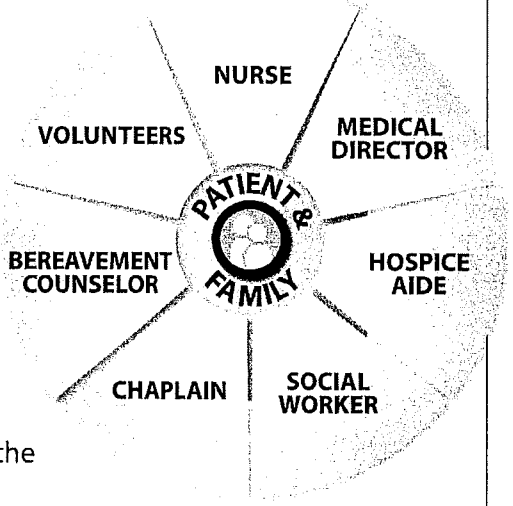
and We'll Be There, Every Step of the Way.

At Amedisys, we take pride in the quality of our home health care and in the services we provide to our community. We also recognize that as time passes, **your goals for care and healthcare needs might change.**

That's why we're proud to offer additional services and levels of care, right here within our Amedisys family. This includes our **Hospice Services**, provided by some of the region's most talented, compassionate, and experienced hospice specialists and bolstered by our unique **"open access" philosophy.**

With our specialized hospice care program ...

- We care for **all eligible patients** (life expectancy of six months or less).
- We do not require you to give up on **hope for cure or recovery**.
- We provide **aggressive pain and symptom management**, emotional and spiritual support, and **quality of life**, supporting both the patient and the entire family.
- We work specifically to help you **achieve your personal goals** and to bring joy, comfort, and fulfillment into every moment possible.
- We allow you to **continue your current treatments**, especially those focused on improving your quality of life. This includes artificial nutrition, blood transfusions, and much more. Additionally, we will never require that you sign a DNR as a condition of your admission to hospice.
- We will **cover 100% of the costs of all care, medications, equipment, and supplies** related to your terminal illness (for patients covered by Medicare and for many Medicaid and commercial insurances).



So while your needs, goals, and priorities might change throughout the course of your care, we offer the right level of care, at the right time, wherever you call home.

Amedisys® Home Health Care

www.amedisys.com

To learn more about our hospice care, talk with your home health specialist.

EXHIBIT 9

Is Hospice the Answer?

Facing a serious illness for the first time can be overwhelming for both the patient and the entire family – especially if you don't know **where to turn for answers and support.**

That's where our team of **compassionate hospice specialists** can help. The gift of **hospice** gives patients facing a life-limiting illness the **freedom to live** ALL the days of their lives by offering **comfort, dignity, quality and time.** If you're not sure whether your loved one might be eligible for hospice care, this brief questionnaire might help...

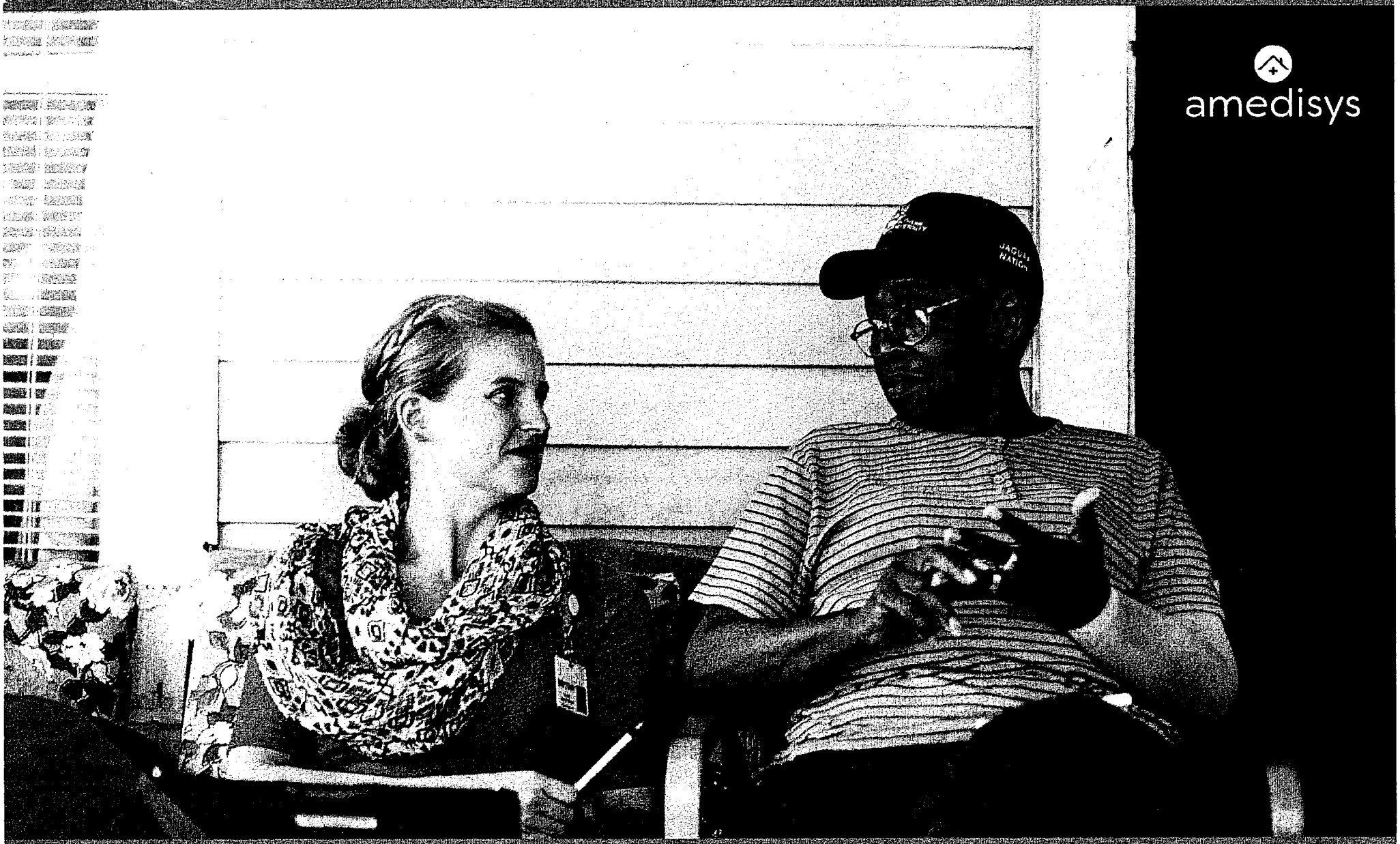
Have you or your loved one...	YES	NO
1. Been hospitalized or gone to the emergency room several times in the past six months?	☐	☐
2. Been making more frequent phone calls to his or her physicians?	☐	☐
3. Started taking medication to lessen physical pain?	☐	☐
4. Started spending most of the day in a chair or bed?	☐	☐
5. Fallen several times over the past six months?	☐	☐
6. Started needing help from others with one or more of the following? (bathing, dressing, eating, getting out of bed, walking)	☐	☐
7. Started feeling weaker or more tired?	☐	☐
8. Experienced weight loss so that clothes are noticeably looser?	☐	☐
9. Noticed a shortness of breath, even while resting?	☐	☐
10. Been told by a doctor that life expectancy is limited?	☐	☐

If you answered "yes" to four or more of the questions above, hospice could be the answer for you and your loved one. Hospice can help manage the physical, emotional, and spiritual needs of the patient, while also supporting the needs of the family.

www.amedisys.com

To learn more about our hospice care, talk with your home health specialist.

EXHIBIT 10



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Amedisys First Quarter 2017 Earnings Call Supplemental Slides

May 3, 2017

Forward-looking statements

This presentation may include forward-looking statements as defined by the Private Securities Litigation Reform Act of 1995. These forward-looking statements are based upon current expectations and assumptions about our business that are subject to a variety of risks and uncertainties that could cause actual results to differ materially from those described in this presentation. You should not rely on forward-looking statements as a prediction of future events.

Additional information regarding factors that could cause actual results to differ materially from those discussed in any forward-looking statements are described in reports and registration statements we file with the SEC, including our Annual Report on Form 10-K and subsequent Quarterly Reports on Form 10-Q and Current Reports on Form 8-K, copies of which are available on the Amedisys internet website http://www.amedisys.com or by contacting the Amedisys Investor Relations department at (225) 292-2031.

We disclaim any obligation to update any forward-looking statements or any changes in events, conditions or circumstances upon which any forward-looking statement may be based except as required by law.

www.amedisys.com

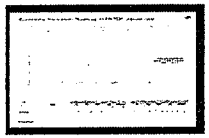
NASDAQ: AMED

We encourage everyone to visit the Investors Section of our website at www.amedisys.com, where we have posted additional important information such as press releases, profiles concerning our business and clinical operations and control processes, and SEC filings.

What Investors Want

Themes from the investor and analyst community that we will address and deliver on in 2017

1



HCHB Disruption Dissipates

- Post 1Q'17, HCHB disruption should no longer impact operations
- HCHB 2.0 training will focus on optimization of the platform aimed at driving improved clinical outcomes and additional margin improvement
- Work on HCHB back office scale opportunities

2

Organic Growth

- **Home Health**: Coming out of 2016 HCHB implementation, a return to mid-single digit growth rates achievable by 2H'17
- **Hospice**: Continued growth at high single / low double digit pace
- **Personal Care**: Added locations in geographies where we have strong Home Health and Hospice overlap to provide integrated solutions

3

M&A

- Strategic and disciplined deployment of capital with a preference to acquire assets in: Hospice, Personal Care tuck-in's, and opportunistic regional acquisitions in Home Health
- Unlevered balance sheet gives us access to capital and lots of options
- Small capital allocation for capabilities building hospital at home, discharge planning, Palliative care and care coordination

4

Impact of Capacity

- HCHB implementation has helped to free clinician capacity. We will focus on leveraging this to help drive productivity and organic growth
- We have also developed and are rolling out a proprietary productivity tool which predicts and optimizes clinician productivity

5

Clinical Distinction

- Amedisys maintains above a 4-Star average (4.13) in the July 2017 HHC preview with 82% of providers at 4+ Stars
- STAR score improvement for the seventh consecutive quarter (from initial July'15 release to Jul'17 preview)
- Ten Amedisys providers rated at 5-Stars in the July 2017 Preview
- Next focus: hospital readmissions

6

Management Team

- Increased operational and execution bench strength
- Experienced management team in place to guide the company post-HCHB implementation particularly in areas of home health growth and driving operational excellence & standardization

7

Regulatory

- Amedisys and The Partnership for Quality Home Healthcare (PQHH) worked collaboratively with CMS and others on the Hill to delay further implementation of PCR
- Continue to work with the new leadership at CMS and Members of Congress on regulatory issues impacting home health and hospice, including the Home Health Groupings Model

8

BD / Sales Restructuring

- Project Redwood helped us with better targeting and better tools (we know where and who to hunt)
- Focus is on hiring and retaining the right BD staff
- Updating incentives to further drive BD productivity and retention
- Training to drive better productivity

Highlights and Summary Financial Results (Adjusted): 1Q 2017[1]

Hospice and Personal Care continue their strong growth. Home Health total episodic admissions up 3% but Medicare FFS down 1%. Cost containment initiatives performing very well driving 1Q EBITDA

1Q'17 — Amedisys Consolidated

- Revenue Growth: +6%
- EBITDA: $32M
- EBITDA Margin: 8.6%
- EPS: $0.47

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1Q'17 — Balance Sheet and Cash Flow

- Net debt: $47M
- Leverage ratio: 0.4x (net)
- CFFO bef. WC change [2] : $42M
- Free cash flow [2] : $23M

1Q'17 — Home Health

Same Store Admissions:
- Medicare FFS: (1%)
- Total Episodic: +3%
- Non-Episodic: (1%)

Other Statistics:
- Medicare recert rate: 35%
- Total cost per visit: +2%

1Q'17 — Hospice

Same Store Volume:
- Admissions: +20%
- ADC: +16%

Other Statistics:
- Cost per day: (4%)

1Q'17 — Personal Care

Growth Metrics [3]:
- Billable hours/quarter: +53%
- Clients served: +56%
- Closed HomeStaff acquisition and signed East TN Personal care
- Largest provider of personal care services in Mass.

1Q'17 — Adjusted Financial Results

$ in Millions, except EPS	1Q16	1Q17
Home Health	272.7	271.3
Hospice	73.0	85.6
Personal Care	3.1	13.6
Total Revenue	**$ 348.8**	**$ 370.5**
Gross Margin %	*42.1%*	*41.8%*
Adjusted EBITDA	**23.9**	**32.0**
	6.9%	***8.6%***
Adjusted EPS	**$0.33**	**$0.47**
Free cash flow [2]	$7.8	$23.4

1. *The financial results for the three-month periods ended March 31, 2016 and March 31, 2017 are adjusted for certain items and should be considered a non-GAAP financial measure. A reconciliation of these non-GAAP financial measures is included in the corresponding 8-K detailing quarterly results for each respective reporting period.*
2. *CFFO before working capital change defined as cash flow from operations before working capital changes. Free cash flow defined as cash flow from operations less routine capital expenditures and required debt repayments.*
3. *Includes acquisitions and full 1Q'16 impact of AHC (deal closed in March 2016)*

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Home Health and Hospice Segment (Adjusted) – 1Q 2017[1]

Home health financial performance steady despite reimbursement cut; hospice continues to outperform

HOME HEALTH $ in Millions	1Q16	1Q17
Medicare	206.8	198.7
Non-Medicare	65.9	72.6
Home Health Revenue	**$272.7**	**$271.3**
Gross Margin %	*41.0%*	*39.9%*
Segment EBITDA [2]	**38.2**	**36.6**
	14.0%	*13.5%*
Operating Statistics		
Medicare admit growth - same store	4%	(1%)
Medicare recertification rate	36%	35%
Medicare admits	50,418	49,628
Medicare recertifications	26,023	25,043
Non-Medicare episodic admits - same store	11%	35%
Non-Medicare non-epiosidc admits - same store	10%	(1%)
Total Cost per visit	$87.45	$89.61

HOSPICE $ in Millions	1Q16	1Q17
Medicare	68.7	80.7
Non-Medicare	4.3	4.9
Hospice Revenue	**$73.0**	**$85.6**
Gross Margin %	*46.8%*	*50.5%*
Segment EBITDA [2]	**16.6**	**22.6**
	22.7%	*26.4%*
Operating Statistics		
Admit growth - same store	19%	20%
ADC growth - same store	22%	16%
Admits	5,430	6,505
ADC	5,507	6,365
Revenue per day	$145.65	$149.41
Cost per day	$77.36	$74.08

Home Health Highlights

- Overall same store episodic admit growth was solid (+3%) driven by non-Medicare episodic admits (+35%); offset by decline in Medicare same store admissions (-1%)
- CPV increase anticipated due to planned salary increases and health care costs

Hospice Highlights

- Eighth straight quarter of double digit same store admissions growth
- Net revenue per day up 3% y/y; gross margin expanded 370 basis points
- Cost per day down 4%; segment EBITDA contribution up 36%

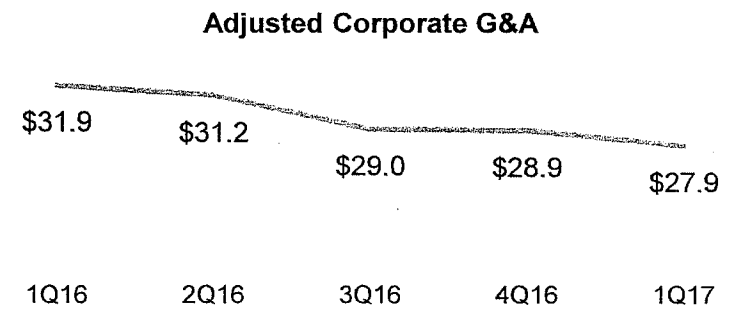
1. *The financial results for the three-month periods ended March 31, 2016 and March 31, 2017 are adjusted for certain items and should be considered a non-GAAP financial measure. A reconciliation of these non-GAAP financial measures is included in the corresponding 8-K detailing quarterly results for each respective reporting period.*
2. *Segment EBITDA does not include any corporate G&A expenses*

General & Administrative Expenses – Adjusted [1,2]

Impact of G&A cost control materializing as operational efficiencies are realized

$ in Millions, except EPS	1Q16	2Q16	3Q16	4Q16	1Q17
Home Health Segment	70.4	71.3	70.7	67.4	68.0
% of Home Health Revenue	*25.8%*	*25.9%*	*26.3%*	*25.2%*	*25.1%*
Hospice Segment	16.9	17.3	17.4	18.0	18.0
% of Hospice Revenue	*23.1%*	*22.6%*	*21.2%*	*21.1%*	*21.0%*
Personal Care Segment	0.4	2.3	2.2	2.9	3.3
% of Personal Care Revenue	*12.7%*	*24.5%*	*20.6%*	*22.8%*	*24.3%*
Total Corporate	31.9	31.2	29.0	28.9	27.9
% of Total Revenue	*9.1%*	*8.6%*	*8.0%*	*7.9%*	*7.5%*
Total	**119.6**	**122.1**	**119.3**	**117.2**	**117.2**
% of Total Revenue	***34.3%***	***33.8%***	***33.0%***	***32.1%***	***31.6%***

$ in Millions, except EPS	1Q16	2Q16	3Q16	4Q16	1Q17
Corporate Expense Detail					
Salary and Benefits	14.0	13.8	13.8	13.7	13.9
Other	14.8	14.1	12.4	11.8	11.6
Corp. G&A Subtotal	**28.8**	**27.9**	**26.2**	**25.5**	**25.5**
Non-cash compensation	3.1	3.3	2.8	3.4	2.4
Adjusted Corporate G&A	**31.9**	**31.2**	**29.0**	**28.9**	**27.9**



Notes:

- Year over year total G&A as a percentage of revenue decreased 270 basis points
  - Home health segment G&A: 70 bps y/y decrease as % of revenue
  - Hospice segment G&A: 210 bps decrease y/y as % of revenue
  - Corporate G&A: 160 bps decrease y/y as % of total revenue
- **Excluding G&A from our new personal care segment; G&A has decreased over $5M in 1Q17 vs. 1Q16**

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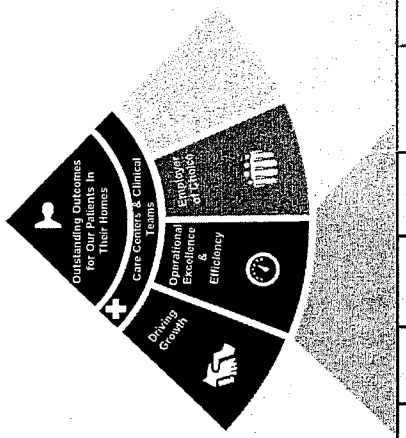
1. *The financial results for the three-month periods ended March 31, 2016, June 30, 2016, September 30, 2016, December 31, 2016, and March 31, 2017 are adjusted for certain items and should be considered a non-GAAP financial measure. A reconciliation of these non-GAAP financial measures is included in the corresponding 8-K detailing quarterly results for each respective reporting period.*
2. *Adjusted G&A expenses do not include bad debt expense or depreciation and amortization.*

How we're tracking



Status	Category	Update	Ongoing Initiative
●	STARS / Quality	Amedisys maintains a 4-Star average in the July 2017 HHC release with 82% of providers at 4 stars or better. Industry leading quality in hospice	• Rolled out new heart failure program with additional protocol driven programs underway.
◐	Protocols / Clinical Standardization	Create innovative industry-leading, clinical programs and define, develop and implement standardized care protocols at point of care. Heart program rolled out in Feb. 2017, COPD on-track	
●	Turnover	Overall turnover was 22.3% with full time turnover at 18.6%. Customized voluntary turnover goals rolled out to each organization aimed at maintaining turnover targets	• Continued focus on retention through engagement and development opportunities. Increased emphasis on HH BD turnover.
○	Productivity	Proprietary productivity & staffing tool has rolled out. The tool will help drive increased capacity, higher productivity, and optimize professional mix to help manage cost per visit (CPV)	
●	HCHB Rollout & Disruption	Completed installation in 15 months – no expected impact beyond 1Q'17. Working on clean-up of 2016 impacts (A/R)	• Post 1Q'17, no additional expected HCHB disruption • Focus shifted to HCHB 2.0 training • A/R increase related to process changes from HCHB implementation (billing from two systems until AMS2 wind down). Goal to drive DSO number down to mid 30's by 2H'17
◐	HCHB 2.0	Re-training the field to become system "super-users" or drive more efficiencies and organizational standardization.	
●	Cost Initiatives	Execution on cost containment initiatives has been successful to date– we continue to be on pace to deliver targeted savings by 4Q'17	
○	Accounts Receivable	DSO remained steady at 40 from 4Q 2016 to 1Q 2017. Expect to be normalized by 3Q'17	
○	Home Health	Achieved 3% total episodic growth with slightly negative Medicare FFS growth. BD reorg efforts underway, still target mid-single digit growth in 2H'17	• Implementing Home Health Sales / BD Reorg initiatives • Targeting 4-6% annual organic growth rate in Home Health in 2H17 • Focusing M&A efforts on hospice and personal care, while maintaining multiple discipline • Positive outcome with the further delay of PCR in FL. • HHGM next to address
●	Hospice	Hospice performance continues to be stellar. SS Hospice admissions +20%. 8th consecutive quarter of double digit growth	
●	Personal Care	Billable hours/quarter: +53%, Clients served: +56%. Integration process highly efficient. Targeting acquisitions	
○	M&A	Closed HomeStafff and signed Tenet and East TN Personal Care deals in 1Q. Pipeline remains strong ($100M+ EBITDA), maintaining pricing discipline and focusing on Hospice acquisitions	
○	Reimbursement	PCR pilot in Florida delayed. Focus now turned to working collaboratively with CMS on Home Health Groupings Model and other regulatory issues impacting Home Health and Hospice	

Clinical Distinction: Improvements in STARS

7th consecutive quarter of QPC STAR score improvement; 82% of providers at 4 stars or better

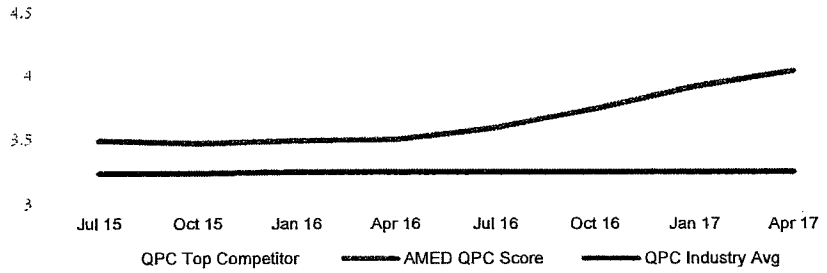
Quality of Patient Care (QPC)

Metric	Jan 17 Release	Apr 17 Release	Jul 17 Preview
Quality of Patient Care	3.91	4.03	4.13
Entities at 4+ Stars	65%	75%	**82%**

Patient Satisfaction (PS)

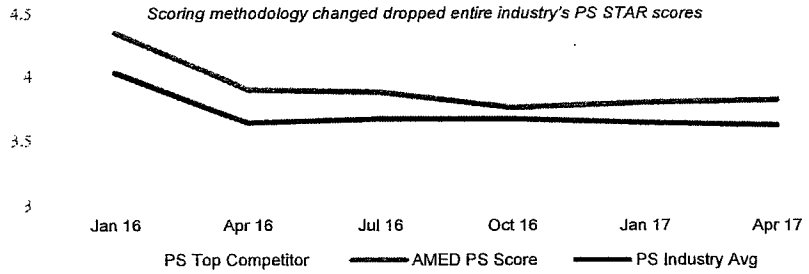
Metric	Oct 16 Release	Jan 17 Release	Apr 17 Release
Patient Satisfaction Star	3.76	3.80	3.82
Performance Over Industry	+5%	+4%	+5%

QPC Industry Performance



PS Industry Performance

Scoring methodology changed dropped entire industry's PS STAR scores



- Amedisys maintains a 4-Star average in the July 2017 HHC release with 82% of providers at 4+ Stars
- STAR score improvement for the seventh consecutive quarter (from initial July'15 release to Jul'17 preview)
- Ten Amedisys providers rated at 5-Stars in the July 2017 Preview (represents15 care centers)
- Patient Satisfaction (HHCAHPS) results remain stronger than overall industry average

Stars and Growth*

FY 2015 vs. FY 2016

APR 17 Provider Rating	Provider #'s	Growth
≤★★★★	103 (60%)	1.7%
★★★★½ /★★★★★	70 (40%)	5.4%

- At the Overall Star Rating level, we continue to see our highest rated agencies grow at a faster pace than lower rated agencies. For this time period Amedisys had 0 agencies rated below 3.5 Stars

Value Based Purchasing

Performance in VBP States Relative to Industry

	QPC	PS
Amedisys VBP State Avg	**4.09**	**3.69**
Large Cohort VBP Comp Avg[1]	3.61	3.55

Note: *Top Competitor Avg weighted by CCN count and include LHC, Kindred, AFAM, HLS and BKD*

VBP: Internal analysis suggests that we will be a net receiver of funds in 2018

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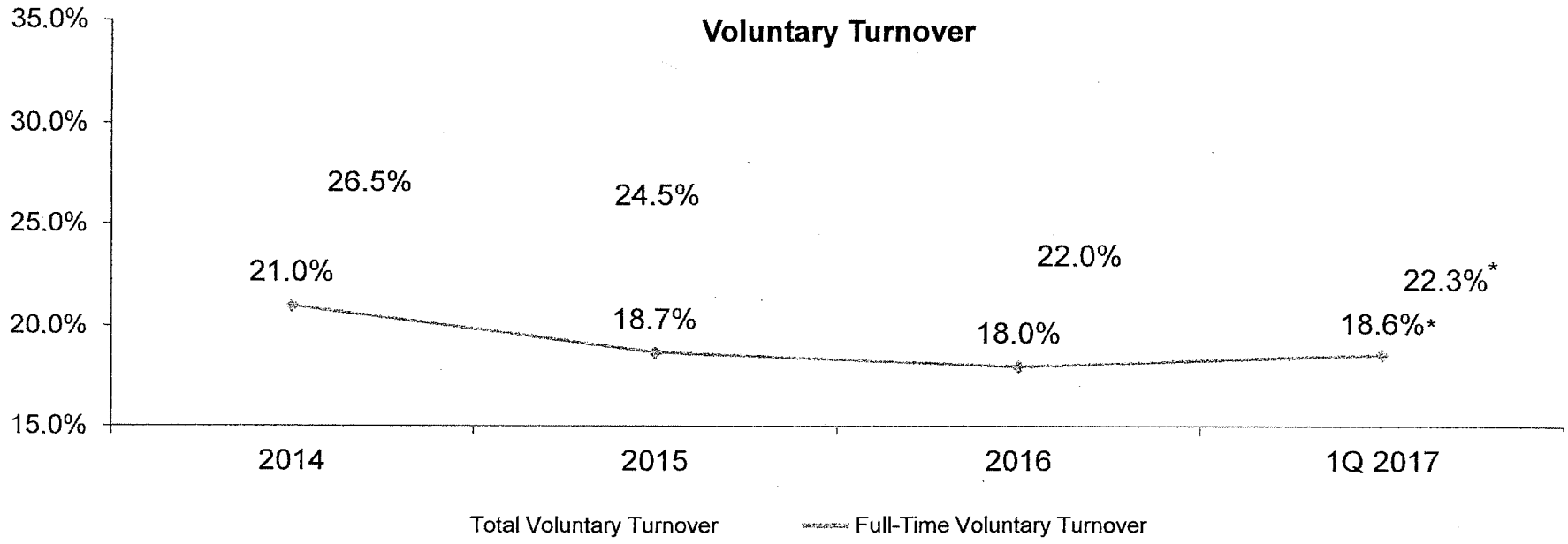
Becoming Employer of Choice: Improving Return on Human Capital

Voluntary turnover company-wide has been trending down despite slight increase in Q1'17



Notes:

- Total voluntary turnover in 1Q'17 increased slightly:
  - **Customized voluntary turnover goals rolled out to each organization aimed at maintaining turnover targets**
  - **Full-time voluntary turnover was 18.6% for 1Q'17**
- Proprietary productivity tool to maximize visiting clinician's capacity has been rolled out – achievement will support 2017 growth targets

*Trailing 12 months

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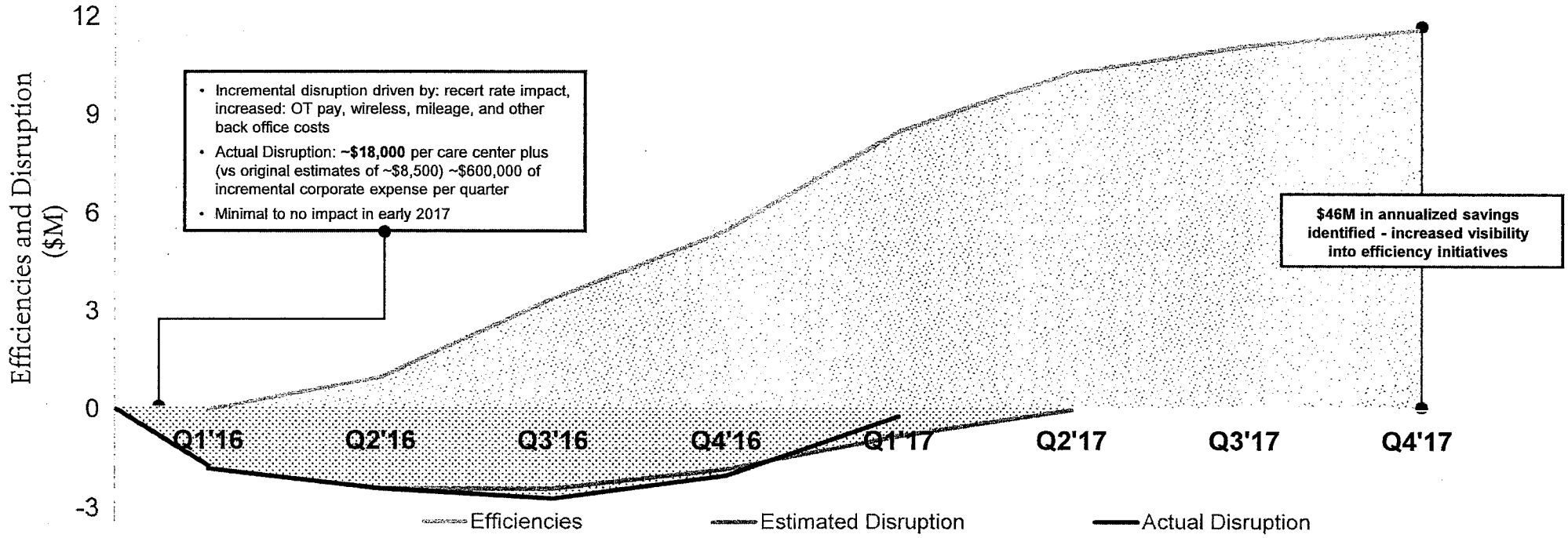
Operational Excellence: Roadmap to EBITDA Improvement

We continue to make progress towards our stated operational efficiencies ($46M annualized improvement vs. 2015 exit run rate)



Efficiencies and Disruption

($M)	Q1	Q2	Q3	Q4	FY 2016	Q1	Q2(E)	Q3(E)	Q4(E)	FY 2017
Efficiencies	$ -	$ 1.0	$ 3.5	$ 5.5	$ 10.0	$ 8.5	$ 10.3	$ 11.1	$ 11.6*	$ 41.5
Disruption										
Estimated	$ (1.8)	$ (2.4)	$ (2.4)	$ (1.8)	$ (8.4)	$ (0.8)	$ -	$ -	$ -	$ (0.8)
Actual	**$ (1.8)**	**$ (2.4)**	**$ (2.7)**	**$ (2.0)**	**$ (8.9)**	**$ (0.2)**	$ -	$ -	$ -	**$ (0.2)**

*Run Rate $46 million

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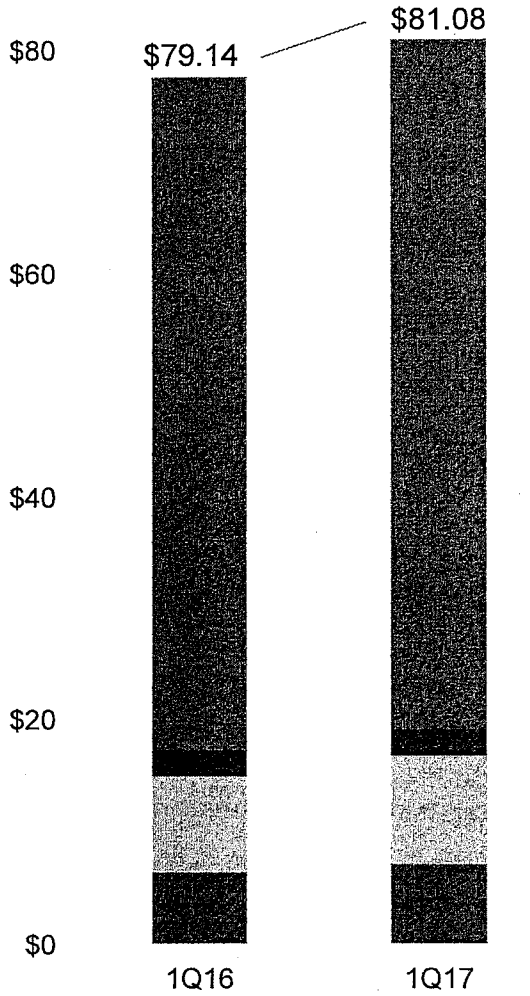
Operational Excellence: Cost Per Visit (CPV)

CPV increase driven by planned raises and health insurance costs; opportunities for savings through optimized clinician mix and focus on transportation and supply cost

Visiting Staff Cost Per Visit



Components	4Q'16	1Q'16	1Q'17	YoY Variance	Detail	Mitigation Plan
Salaries	$62.94	$60.48	$61.48	$1.00	$0.68 driven by planned salary increases $0.32 driven by utilization	Initiatives in progress to drive down costs by labor mix optimization, productivity improvements and improved scheduling tools
Contractors	$2.17	$3.10	$2.35	($0.75)	Trend down since 1Q16	Contractor utilization decreases as clinician capacity increases post HCHB
Benefits	$11.10	$9.09	$10.09	$1.00	Health insurance driving increase	Focused on cost containment and spend optimization
Transportation & Supplies	$7.25	$6.47	$7.16	$0.69	Increase primarily due to supply costs	Continues to normalize post HCHB rollout - Supplies costs increased in 4Q'16
*Visiting Staff CPV	$83.46	$79.14	$81.08	$1.94		
Clinical Managers	$9.01	$8.31	$8.53	$0.22	Fixed cost associated with non-visiting clinicians	Unit cost reduced as volume increases
Total CPV	$92.47	$87.45	$89.61	$2.16		

*Note: Direct comparison with industry competitors CPV calculation

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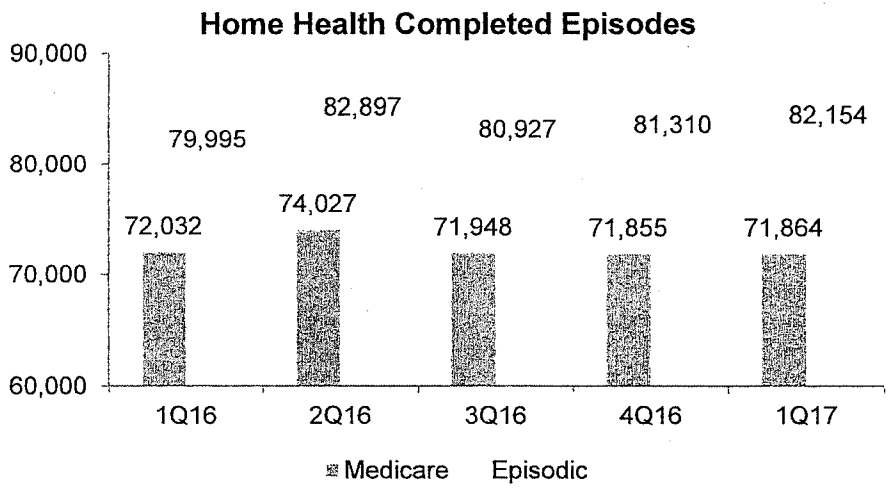
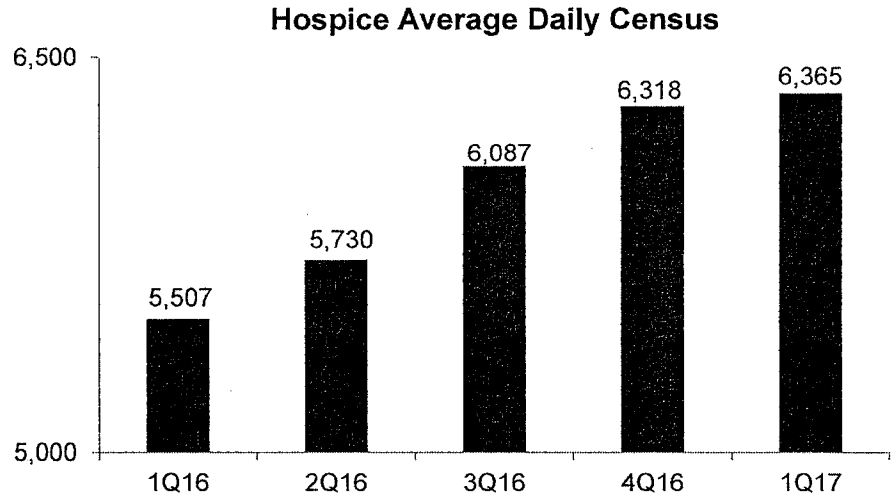
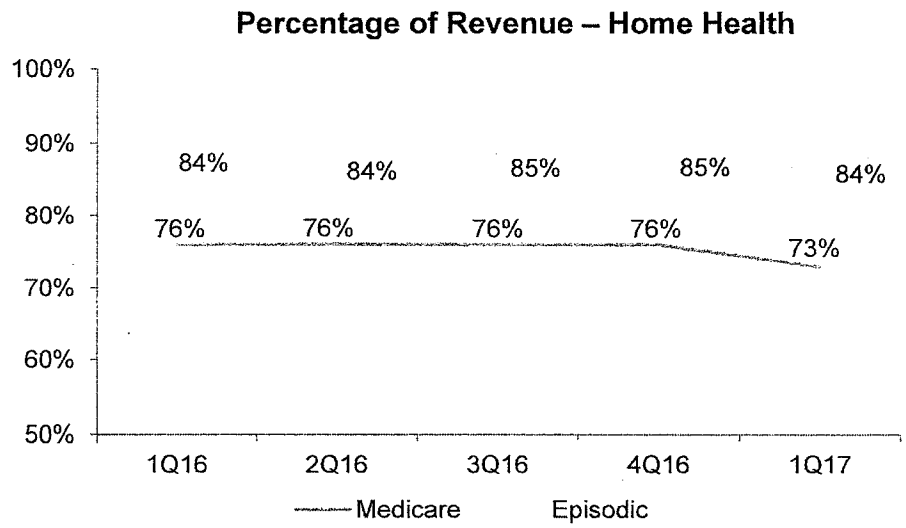
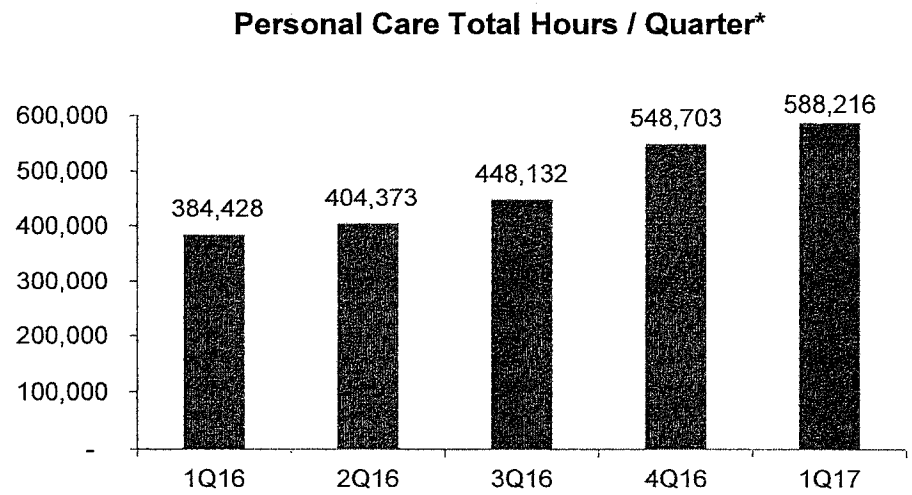
Driving Top Line Growth: Metrics Across Business Segments

Solid growth in hospice and personal care; Medicare revenue decrease due to reimbursement cut and significant growth in private episodic









* Includes acquisitions, (384,428 hours represents full 1Q performance – AMED closed AHC acquisition in March of 2016)

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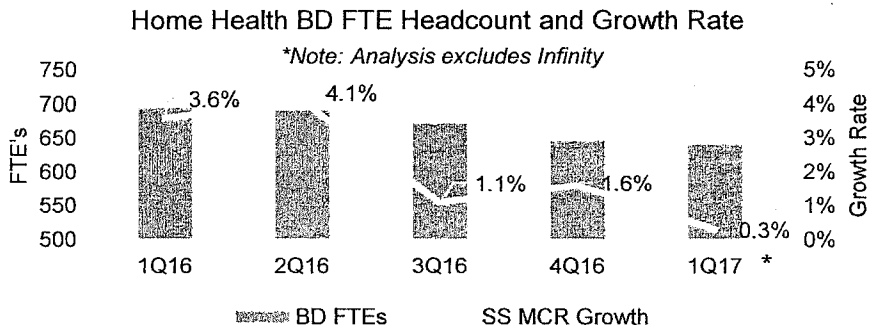
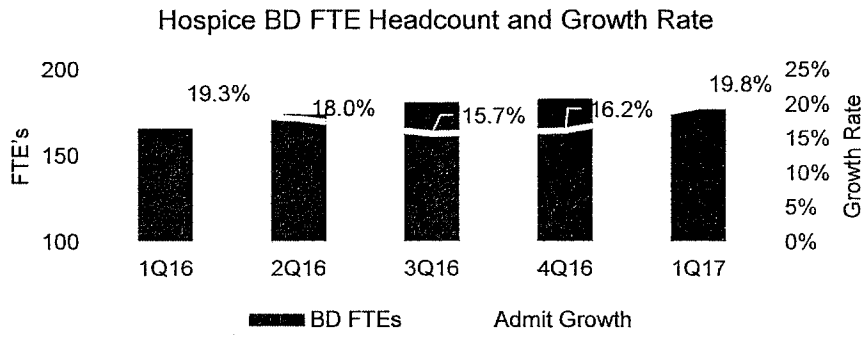
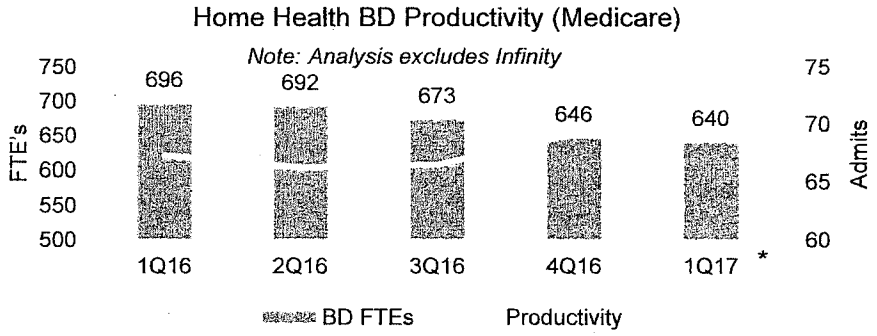
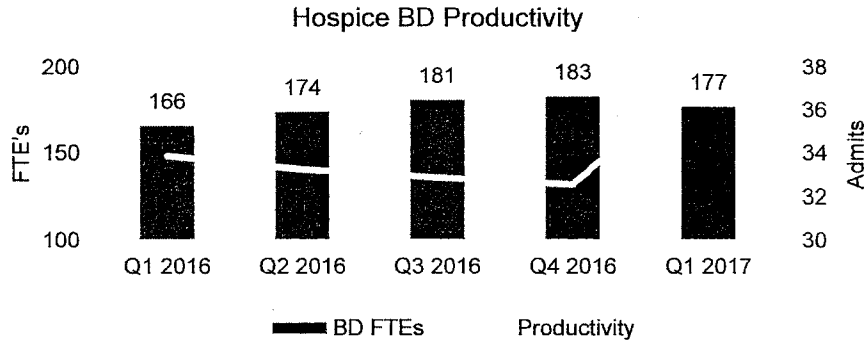
Driving Top Line Growth: Business Development Impact Analysis

Unintended business development turnover has impacted overall growth in home health; however, productivity has increased. Hospice investment in business development has paid dividends









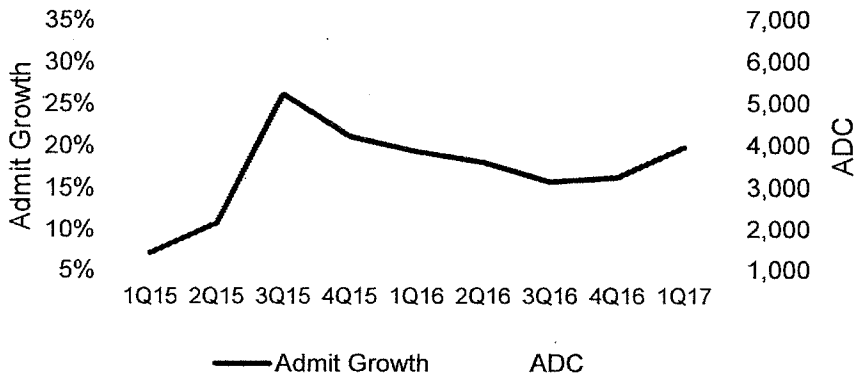
Notes:

- The Home Health BD reorg (Project Redwood) implemented in 2016 taught us a number of things. We now have better tools and a more analytical approach to account targeting which has translated into a more productive sales force. The increased productivity however, was not enough to offset the unintended BD turnover. As we uncovered this unintended turnover, we have taken measures to add back BD FTE's, which will have a positive impact on growth
- The Hospice organization did not experience the same unintended turnover during their BD reorg. As such, Hospice, armed with a fully staffed BD team with better targeting and account management tools, has seen substantial growth

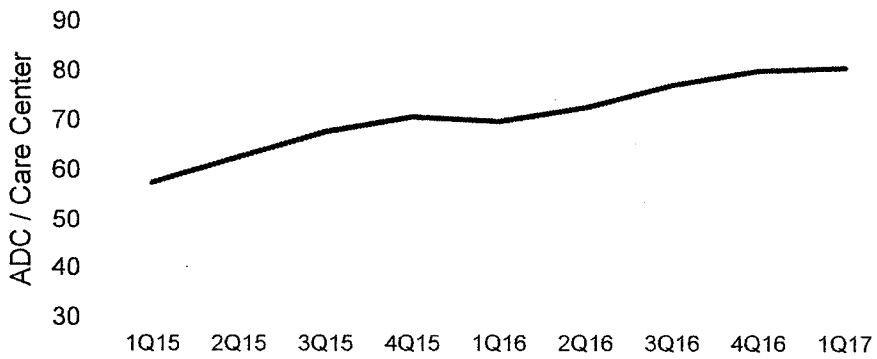
Driving Top Line Growth: Hospice Success

In 2015, we made a concerted effort to improve our Hospice business unit. Since that time, Hospice has enjoyed eight consecutive quarters of top line growth, vast increases in ADC per care center and operating margin improvement via a disciplined approach to G&A

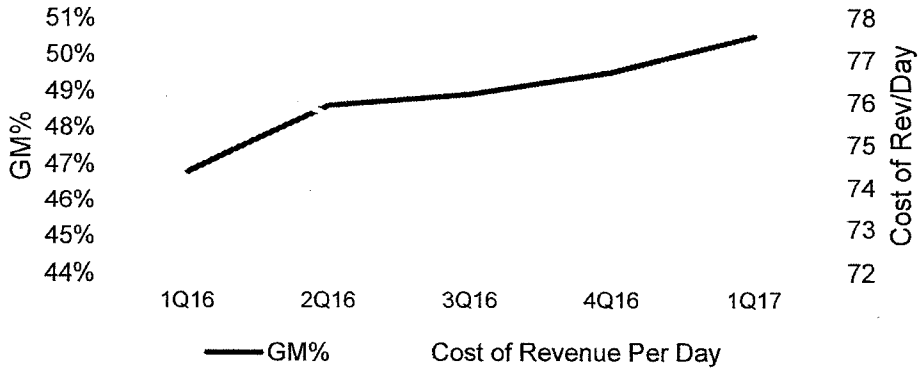
Admit growth and ADC build began in Q3 2015 and admit growth has remained above 15%



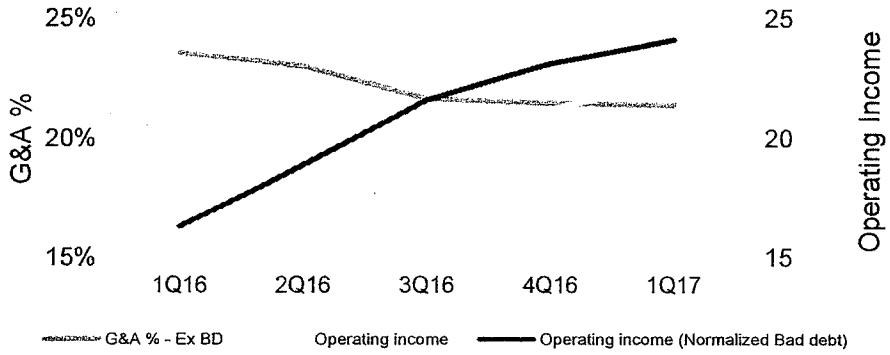
ADC per Care Center



Staffing model and cost control has allowed for Margin expansion



G&A discipline allowed for signifcant increase in segment operating income



Debt and Liquidity Metrics

Low debt levels and strong cash flow have improved the flexibility of our balance sheet with ample available liquidity

Outstanding Debt	As of: 03/31/17
Term Loan	93.7
Outstanding Revolver / Other Notes Payable	1.1
Total Debt Outstanding	**94.8**
Less: Deferred Finance Fees	(2.4)
Total Debt - Balance Sheet	**92.4**
Total Debt Outstanding	94.8
Less: Cash	(48.3)
Net Debt	**46.5**
Leverage Ratio (net) [1]	**0.4x**

Credit Facility	As of: 03/31/17
Revolver Size	200.0
Oustanding Revolver	-
Letters of Credit	29.6
Available Revolver	**170.4**
Plus: Cash	48.3
Total Liquidity [2]	**218.7**

Credit facility and cash provide significant capital for accretive acquisitions and/or other capital deployment options

1. *Net debt defined as total debt outstanding ($95M) less cash balance ($48M). Leverage ratio (net) is defined as net debt divided by last twelve months adjusted EBITDA ($118M).*
2. *Liquidity defined as the sum of cash balance and available revolving line of credit.*

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Adjusted EBITDA to Free Cash Flow Reconciliation [1,2]

Reduction in amount of non-GAAP adjustments result in adjusted EBITDA falling through to operating cash flow; looking return DSO to mid-30's by YE'17. Capex target within projected goal for 2017

$ in Millions	1Q16	2Q16	3Q16	4Q16	1Q17
GAAP Net Income	6.2	10.7	11.4	8.9	15.1
Taxes	4.4	7.2	6.7	5.6	9.9
Interest	1.1	1.3	1.1	1.6	1.1
Depreciation and amortization	4.5	5.0	5.2	5.0	4.4
Adjustments	7.8	5.6	1.2	9.4	1.5
Adjusted EBITDA	**23.9**	**29.8**	**25.6**	**30.5**	**32.0**
Provision for doubtful accounts	3.9	4.2	5.5	5.9	6.3
Non-cash compensation, includes 401(k) match expense	5.8	5.4	6.4	5.6	6.1
Cash taxes	-	(0.8)	-	-	(0.3)
Cash interest	(0.6)	(0.7)	(0.9)	(0.6)	(0.7)
Other	(10.9)	(14.1)	(1.8)	(4.9)	(1.9)
	22.1	**23.8**	**34.8**	**36.5**	**41.5**
Changes in working capital	(9.9)	(9.1)	(28.0)	(7.9)	(14.4)
Cash Flow from Operations	**12.2**	**14.7**	**6.8**	**28.6**	**27.1**
Capital Expenditures - Routine	(3.1)	(2.0)	(1.6)	(0.1)	(2.4)
Required debt repayments	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)
Free cash flow	**7.8**	**11.4**	**3.9**	**27.2**	**23.4**
Capital Deployment					
Acquisitions	(27.7)	-	(3.7)	(4.1)	(4.1)
Share Repurchases	(12.3)	-	-	-	-
Total	**(40.0)**	**-**	**(3.7)**	**(4.1)**	**(4.1)**

1. *The financial results for the three-month periods ended March 31, 2016, June 30, 2016, September 30, 2016, December 31, 2016 and March 31, 2017 are adjusted for certain items and should be considered a non-GAAP financial measure. A reconciliation of these non-GAAP financial measures is included in the corresponding 8-K detailing quarterly results for each respective reporting period.*
2. *Free cash flow defined as cash flow from operations less routine capital expenditures and required debt repayments.*

Income Statement Adjustments [1]

Amount of non-GAAP adjustments through 2016 have substantially decreased in 1Q'17

$000s	Income Statement Line Item	1Q16	2Q16	3Q16	4Q16	1Q17
Reduction of cost report reserve	Revenue				(1,149)	
Third Party Audit reserve	Revenue		948			
G&A						
Acquisition costs	G&A, Salary and benefits	502	154	101	56	
Restructuring Activity	G&A, Salary and benefits	1,149	1,201	2,044	3,340	
HCHB implementation	G&A, Salary and benefits		307	56	15	
Restructuring Activity	G&A, Non-cash compensation		(556)	(493)	(1,481)	
Restructuring Activity	G&A, Other	613	840	414	16	
Data Center Relocation	G&A, Other	448	9		101	714
HCHB implementation	G&A, Other	2,440	2,286	1,937	1,330	
Acquisition costs	G&A, Other	1,202	183	366	820	682
Legal fees - non-routine	G&A, Other	616	459	374	543	123
Frontier Litigation	G&A, Other	500			2,479	
Wage and Hour litigation	G&A, Other	401			(119)	
Disaster relief	G&A, Other			339	129	
Sales/use tax audit reserve	G&A, Other				460	
Other Items						
Asset impairment	Asset impairment				4,432	
Legal settlements	Other, Miscellaneous, net	(541)	(265)	(1,242)	(280)	(674)
Sales/use tax audit reserve	Other, Miscellaneous, net				625	
Miscellaneous, other (income) expense, net	Other, Miscellaneous, net	436	70	(2,738)	(1,318)	621
Total		**7,766**	**5,636**	**1,158**	**9,999**	**1,466**
EPS Impact		**$0.14**	**$0.10**	**$0.02**	**$0.18**	**$0.03**

1 *The financial results for the three-month periods ended March 31, 2016, June 30, 2016, September 30, 2016, December 31, 2016, and March 31, 2017 are adjusted for certain items and should be considered a non-GAAP financial measure. A reconciliation of these non-GAAP financial measures is included in the corresponding 8-K detailing quarterly results for each respective reporting period.*

EXHIBIT 11

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

520 Upper Chesapeake Drive
Bel Air, MD 21014
uchs.org

Angela Poppe Ries, MD
Director of Palliative Care
University of Maryland Upper Chesapeake Health
443-643-2696

June 4, 2017

Mr. Kevin McDonald
Chief, Certificate of Need Division
Center for Healthcare Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215
p- 410-764-5982
f- 410-358-1236

Re: Support of CON Application filed by Amedisys Maryland, LLC. ("Amedisys") to Provide Hospice Care in Prince George's County

Dear Mr. McDonald:

This letter affirms my unconditional support of Amedisys's Certificate of Need application to provide hospice services in Prince George's County. As the medical director of palliative care services at the University of Maryland Upper Chesapeake Health in Harford County, I engage with many home health and hospice providers. The care and service provided by Amedisys Hospice exceeds all other hospice organizations in our area.

Amedisys's "Yes" attitude and care means that their patients receive the highest quality care, everything from offering palliative radiation therapy at the end of life to partnering with other organizations like the Veterans Affairs Administration and local hospitals to ensure seamless support. Our hospitalized patients can transition to Amedisys Hospice while still within our four walls so that their care is optimized and transitions minimized. Thus, bringing Amedisys Hospice to Prince George's County guarantees unmatched patient care and patient choice for the residents of that county.

Amedisys has my full endorsement to be the hospice agency of choice for residents of Prince George's County.

Sincerely,

MD

Angela Poppe Ries, MD

BORIS KERZNER, M.D.
INTERNAL MEDICINE
2700 QUARRY LAKE DR., SUITE 200
BALTIMORE, MARYLAND 21209
410-415-5811 PHONE
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June 5, 2017

Mr. Kevin McDonald
Chief, Certificate of Need Division
Center for Healthcare Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215
p- 410-764-5982
f- 410-358-1236

Re: Support of CON Application filed by Amedisys Maryland, LLC. ("Amedisys") to Provide Hospice Care in Prince George's County

Dear Mr. McDonald:

Please accept this letter in support of Amedisys's Certificate of Need application to provide Hospice services in Prince George's County. As internist and medical director with Amedisys in Baltimore County, I have been able to witness how Amedisys has enabled and supported the nurses and staff to deliver excellent care to patients and their caregivers. The patients uniformly are pleased and appreciative of the care and attention they receive.

The structure that Amedisys has built is very impressive and accounts for its ability to initiate a rapid response for patients being discharged from inpatient hospital care to at home hospice care.

The addition of Amedisys Hospice to Prince George's County not only will increase patient access to Hospice Care, but it also will increase the quality of choices my patients have in choosing a Hospice provider. Amedisys employs state-of-the-art technology to provide care to all patients, wherever they reside.

I therefore strongly endorse Amedisys as the best provider to meet the Hospice needs of Prince George's County.

Sincerely,

Boris Kerzner MD.