Medi-Cal Further Rate Review of Access to Home Health Agency Services for 2001-2005

Prepared by:
Department of Health Care Services
Fee-For-Service Rate Development Division

Release Date: March 2013

I

BACKGROUND

In June 2008, the Department of Health Care Services (Department) issued a report entitled "Medi-Cal Home Health Rate Review with Consideration of Efficiency, Economy, Quality of Care, and Access." The report summarized the Department's findings as to whether the Medi-Cal rates paid to home health agency (HHA) providers for 2001-2005 complied with the "efficiency, economy, and quality of care" (EEQ) provision and the Access provision of 42 United States Code section 1396a(a)(30)(A). On March 26, 2012, the California Court of Appeal (Third Appellate District) published a decision concerning the Department's June 2008 report in the case of *California Association of Health Services at Home* v. *Department of Health Care Services* at 204 Cal. App. 4th 676. The Court of Appeal held that the Department had reasonably considered and determined that the rates paid in 2001-2005 complied with the EEQ provision. However, the Court held that the June 2008 report had not adequately supported the Department's findings that the rates complied with the Access provision. This further rate review focuses on the following two problems that the Court of Appeal found with respect to the Department's June 2008 analysis.

First, the Court said the Department had not provided sufficient data concerning home health utilization for 2001-2005 and instead relied on earlier data and a 10% rate increase in 2000, to assume that there was sufficient access in 2001-2005. Second, although the June 2008 report showed that there had been steady growth of 7% in the number of HHA providers participating in the Medi-Cal program during 2001-2005, the Court observed that there had been growth of 26% in the number of California HHA providers participating in the Medicare program during the same period. There was an annual average of 580 HHA providers participating in Medicare during 2001-2005 with a high of 637 in 2005 versus an annual average of 421 HHA providers participating in Medi-Cal during the same period with a high of 449 in 2005. The Court said the plaintiffs had made a persuasive argument that the growing discrepancy in the number of providers available in Medicare and Medi-Cal would cause any reasonable person to question whether Medi-Cal beneficiaries have as much access to home health services as the general population.

The Court of Appeal directed the trial court to issue an order requiring the Department to conduct a further rate review for 2001-2005 in accordance with its decision. On October 11, 2012, the trial court issued an order, requiring the Department

to further review whether Medi-Cal beneficiaries had sufficient access to HHA services in 2001-2005 in accordance with section 1396a(a)(30)(A).[1]

This further review evaluates data relevant to the Court of Appeal's two concerns mentioned above. First, it evaluates data related to Medi-Cal utilization and provider participation for the period 2001-2005. Second, it evaluates data that may be relevant to the difference between the number of HHA providers participating in Medicare and the number of HHA providers participating in Medi-Cal during 2001-2005.

II

ANALYSIS

The lawsuit that resulted in the June 2008 study and the court order requiring this further review challenged the validity of the rates that the Department established and paid in the Medi-Cal fee-for-service system. The lawsuit also concerned the Department's obligation under the State Plan to review the fee-for-service rates paid during 2001-2005 for compliance with section 1396a(a)(30)(A). In the fee-for-service system, providers submit reimbursement claims directly to the State for services they have provided to eligible beneficiaries and are paid rates the Department establishes for each service.[2] In the managed care system, managed care plans that have contracted with the Department establish a network of health care providers that render services to beneficiaries enrolled in a particular plan.

In the Medi-Cal managed care system, each managed care plan determines the rates it pays to providers included in its provider network. In the Medi-Cal managed care system, it is the managed care plan that is inserted "as an intermediary between the patient-recipient and the practitioner-providers." (*Clayworth* v. *Bonta* (E.D. Calif. 2003) 295 F.Supp.2d 1110, 1125.) "In the managed care system, it is the managed care plan that assumes, by its contract with the State, the obligation of providing access and quality care to beneficiaries." (*Id.)*

The Department began a significant expansion of the Medi-Cal managed care system in 1996. This resulted in a reduction of beneficiaries in the Medi-Cal fee-for-service system and an increase of beneficiaries enrolled in managed care plans. This is reflected in fee-for-service eligibility data for 1992-1997 contained in the earlier study.

---

[1] The Access provision of 42 United States Code section 1396a(a)(30)(A) requires that payments to providers be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Any subsequent reference to section 1396a (a) (30) (A) in this report will be a reference to that section of 42 United States Code.

[2] Claims submitted to the State are processed by the Medi-Cal Fiscal Intermediary, which contracts with the Department to administer the Medi-Cal claims processing system.

This further review evaluates the access that Medi-Cal beneficiaries have to fee-for-service HHA services from 2001 to 2005. In August 2000, the Department increased by 10% the fee-for-service reimbursement rates paid to HHAs. After the HHA rates were changed in 1988, they were increased twice in the 1990s, by 6% in 1994 and 1% in 1995. Thus, the 10% rate increase in August 2000 was significant.

A. Utilization Data For 2001-2005

The Department reviewed data on the number of Medi-Cal fee-for-service eligible beneficiaries and utilization of HHA services in the Medi-Cal fee-for-service system for the period of 2001-2005, which is set forth in Table 1 below.

Fee For Service Home Health Agency Utlization					
Year	FFS Medi-Cal Eligibles[1]	Avg Monthly Users[2]	Annual Expenditures[2]	Units per User[2]	% of Medi-Cal Users[3]
2001	2,705,826	6,738	$ 147,014,000	2.26	0.249%
2002	2,960,783	6,465	$ 149,059,700	2.45	0.218%
2003	3,150,971	7,373	$ 157,454,000	2.50	0.234%
2004	3,286,032	7,158	$ 162,194,000	2.76	0.218%
2005	3,278,666	6,230	$ 161,395,000	3.10	0.190%

[1] This represents the number of certified fee-for-service eligible Medi-Cal beneficiaries as of July of each calendar year according to the Monthly Medi-Cal Eligibility File. A certified eligible beneficiary is a person with no unmet share of cost obligation.

[2] Data on the average monthly HHA users, units per user, and annual expenditures was calculated based on the final actual numbers for calendar years 2001-2005 reflected in the Medi-Cal Local Assistance Budget Estimates for November 2002 through November 2007. Exhibit A to the study contains this source documentation. Each November estimate includes both estimated numbers for current periods and "actual" numbers for previous periods. The number of average monthly users for each calendar year was determined by calculating the sum of the final actual average monthly users for each quarter of a calendar year and then dividing that number by 4. Similarly, the units per user for each calendar year was determined by calculating the sum of the actual units per user for each quarter of a calendar year and dividing that number by 4. The annual expenditures for each calendar year is the sum of the final actual expenditures for each quarter of the calendar year

[3] Percentage of Medi-Cal users is the percentage of HHA users from the FFS Medi-Cal eligibles (avg. monthly users divided by FFS Medi-Cal eligibles).

Subsequent to the 10% rate increase in August 2000, the table shows that there was steady growth in Medi-Cal fee-for-service expenditures for HHA services for 2001-2005, growing from $147 million expenditures in 2001 to $161.3 million expenditures in 2005. Expenditures are a function of the number of units of service rendered and the rates paid for each service.[3] After the 10% rate increase in August 2000, the rates paid between 2001 and 2005 were the same for all five years. Thus, the increase in Medi-

[3] Each "unit" in table 1 represents a paid claim for an HHA service.

Cal expenditures made to providers during this period is solely a result of the increase in services that HHAs provided to Medi-Cal beneficiaries. The fact that HHAs were submitting more claims to Medi-Cal during this period is further illustrated by the fact that the number of "units" per user steadily increased from 2.25 in 2001 to 3.10 in 2005.

Further illustrating that HHAs were providing an increasing volume of services to Medi-Cal beneficiaries from 2001-2005 is data that was contained in the June 2008 report showing steady increases each year in the number of treatment authorization requests (TAR) that providers submitted for HHA services. Most HHA services must be TAR approved.

There was a significant increase in the number of users in 2003, and then a small reduction in 2004, followed by a reduction to a level in 2005 comparable to 2001. DHCS has not been able to determine exactly why there were more "users" in 2003 and 2004 than in 2001, 2002, and 2005. As explained in more detail below, the number of "users" of HHA services in the fee-for-service system can fluctuate based on a variety of factors that are un-related to the adequacy of the rates being paid. The Department does not believe the changes in the number of users between 2003 and 2005 reflect any problem with the rates being paid. The highest number of users occurred 3 years after the 10% rate increase in August 2000. Also, the average monthly units of service were higher in 2005 than 2003. Based on the number of users and units per user, HHAs rendered a monthly average of 19,096 units of service in 2003 and a monthly average of 19,313 units in 2005. This is consistent with the fact that paid claims steadily increased during the entire period, resulting in increasing Medi-Cal expenditures for HHA services. Thus, the Medi-Cal program paid HHAs $3.9 million more in 2005 than in 2003. There were more HHAs providing services to Medi-Cal beneficiaries in 2005 than in 2001-2004, and they were providing an increasing volume of services to beneficiaries. Therefore, DHCS believes the fluctuation in HHA "users" between 2003 and 2005 had to do with changes in the availability of different types of providers and services for beneficiaries who might otherwise need HHA services, such as those discussed below.

The number of "users" can fluctuate as a result of several factors. For example, even though the 1990s saw only a 6% rate increase one year and 1% increase rate increase another year, the average monthly users of HHA services increased from 5,752 in 1992 to 9,363 in 1997. As explained in the 1998 access study, the primary reason for the growth in HHA users during the 1992-1997 period was a change in Medi-Cal policy to authorize home health care for patients in the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program to cover private duty and shift care for disabled minors in the home.

Similarly, there are several factors contributing to why there are fewer HHA "users" in the Medi-Cal fee-for-service system in 2001-2005 compared to the late 1990s.

First, there are fewer beneficiaries in the Medi-Cal fee-for-service system for each year of 2001-2005 compared to 1992-1997 and more beneficiaries enrolled in managed care plans. Managed care plans are required to provide medically necessary cover home health care services to Medi-Cal beneficiaries enrolled in their plans, except for in-home health care services provided under a Medi-Cal Home and Community Based Services (HCBS) waiver, which is discussed in more detail below. Table 1 shows that the percentage of HHA users out of the Medi-Cal fee-for-service eligible population for 2001-2005 was favorable when compared to the percentages for 1992-1997 described in the earlier study.

The number of HHA "users" can also be impacted by the existence of alternative providers available to provide services that recipients might otherwise receive from HHAs. For example, in 1998, there were 107 adult day health centers (ADHCs) actively enrolled in the Medi-Cal program. In subsequent years, there was a three-fold increase in the number of actively enrolled ADHCs. This growth was triggered in part by a change in law (Senate Bill 1492, statutes of 1994) to allow "for profit" entities to provide ADHC services. The significant growth was almost exclusively from "for profit" ADHCs. By 2001, the number of actively enrolled ADHCs in the Medi-Cal program had doubled to 230. By 2005, the number of actively enrolled ADHCs had increased to 338. ADHCs participating in the Medi-Cal program were required to provide a minimum of 4 hours of service per each day of ADHC attendance. During each day of attendance, ADHCs are required to provide necessary skilled nursing services and therapy services (Cal. Code Regs., tit. 22, § 54309.) These are services that HHAs also provide. The Department believes that the availability of an increasing number of ADHCs participating in the Medi-Cal program is one factor that contributed to a reduction in the number of "users" of HHA services in 2001-2005.

Another contributing factor to there being fewer HHA "users" in 2001-2005 was an increase in the number of individual nurse practitioners (INPs), instead of HHAs, providing EPSDT in-home nursing services. It was not until December 1995 that INPs, not associated with an HHA, could provide these services and bill on their own behalf. INP participation started slowly, but increased substantially in the years after 1997.

Another factor that would have resulted in fewer HHA users was that in 2000, Medi-Cal began to provide coverage of pediatric day health care, in which Medi-Cal EPSDT eligible beneficiaries attend day care facilities that render services that might otherwise have to be provided by an HHA or an INP in the home. (Cal. Code Regs., tit. 22, §§ 51242.1 and 51340, subd. (e).)

Other factors that likely contributed to fewer HHA users in 2001-2005 were changes made in the Medi-Cal Home and Community Based Services (HCBS) waiver program. Under federal Medicaid law, states can ask the federal government to approve a waiver of some federal Medicaid requirements to provide home and community based services to persons that would otherwise require institutional inpatient care, such as that provided by skilled nursing facilities. HCBS services are designed to allow a person otherwise needing institutional care to stay in their home. (42 U.S.C. §

1396n(c).) Federal law requires that the amount that a state spends for HCBS waiver services is not to exceed what the state would spend if a person was instead receiving services in an institutional setting, such as a skilled nursing facility.

The HHA "user" data that the Department reviewed in the earlier study for 1992-1997 and for the 2001-2005 period does not reflect services that HHAs provide under a HCBS waiver program. There was an expansion in the number of people receiving services under HCBS waiver programs in the late 1990s and early 2000s. In 1997 there were only 133 slots for beneficiaries under what was then called the skilled nursing facility waiver program which provided in-home services to beneficiaries that would otherwise require skilled nursing facility care. That waiver was subsequently modified by the early 2000s as the Nursing Facility Level A and B waiver with an increased number of slots available. Thus, in 2001 there were 538 beneficiaries receiving in-home nursing under this HCBS waiver and in 2005, there were 663 beneficiaries receiving in-home services under this waiver. The Department believes this is another contributing factor to there being fewer HHA users showing up in the 2001-2005 "user" data for non-HCBS waiver services.

Another HCBS waiver program that didn't exist in the 1992-1997 period was the subacute HCBS waiver for beneficiaries who would have otherwise received inpatient care in a subacute care facility. In 2001 there were 442 beneficiaries receiving in-home services under this waiver and in 2005 there were 477 beneficiaries receiving in-home services under this waiver. This likely was another contributing factor to there being fewer HHA users showing up in the available 2001-2005 "user" data for non-HCBS waiver services.

There were also changes in HCBS waiver programs in the early 2000s that increased the opportunities for INPs to provide in-home nursing services and also created expanded opportunities for beneficiaries to receive alternative in-home services. For example, up until the early 2000s, such in-home nursing care could only be provided by HHAs. In 2001, the HCBS waiver program was changed to allow INPs to provide such services. The rates paid under the HCBS waiver for in home nursing services provided by either an HHA or by an INP are set forth in 22 California Code of Regulations section 51532.1. These are the same rates paid for in-home nursing under the Medi-Cal EPSDT program, and were increased by 10% in August 2000 to the levels currently set forth in the regulation. But it wasn't until 2001 that INPs could provide in home nursing care to HCBS waiver beneficiaries. Thus, some beneficiaries, who would have shown up in data on HHA "users" in 1992-1997 could instead be receiving in-home nursing from an INP under a HCBS waiver program in 2001-2005. .

A second change in the HCBS waiver program that began in January 2001 was to allow beneficiaries to receive personal care services, as defined in Welfare and Institutions Code section 14132.95, subdivision (d). This led to many beneficiaries in the HCBS waiver program no longer receiving in-home nursing care, as provided by HHAs. The reason for that is two-fold. First, because the rates for personal care services are less than the rates paid for in-home nursing, beneficiaries could get more

hours of care from personal care service providers (PCSPs) and still stay under the HCBS expenditure cap mentioned above. Second, there was a financial incentive for many beneficiaries to switch to receiving personal care services under the waiver because the PCSP could be a qualified relative. For example, if a child of an elderly Medi-Cal beneficiary becomes the PCSP, the Medi-Cal program frequently pays the beneficiary's child for personal care services instead of paying an HHA or INP for in-home health services. For many elderly home bound Medi-Cal beneficiaries, a close relative who is able to provide more hours of care as a PCSP is a better alternative than receiving in-home nursing from either an HHA or an INP.[4]

In summary, the Department finds that the data on Medi-Cal utilization of HHA services for 2001-2005 is consistent with the fact that beneficiaries had sufficient access to HHA services during this period. The fact that there were fewer "users" during 2001-2005 compared to the 1992-1997 period considered in the earlier study had nothing to do with HHAs being unwilling to provide services based on the increased rates established in 2000. The fact that there were fewer HHA users in the fee-for-service system was related to several factors, including fewer fee-for-service eligible beneficiaries, an increase in alternative providers such as ADHCs and pediatric day health care providers, and changes under the HCBS waiver program.

Even if all of the above mentioned non-rate related contributing factors to fewer HHA users were not considered, the percentage of HHA users relative to the Medi-Cal fee-for-service eligible population for 2001-2005 was favorable when compared to the percentages for 1992-1997. The number of HHAs providing services to Medi-Cal beneficiaries increased between 2001 and 2005, and HHA providers provided an increasing volume of care to the users they served, as measured by increasing paid claims and increasing Medi-Cal expenditures over the 5 years. Based on all of the data and other factors discussed above, DHCS concludes that higher rates would not have been justified during the period 2001-2005 to comply with the Access requirement.

B. Provider Comparison between Medi-Cal and Medicare

As noted previously, the prior study determined that there were more HHAs participating in the Medicare program than in the Medi-Cal program for 2001-2005. The Department reviewed this data in relationship to the eligible populations of each program. All Medicare eligible persons are either aged (65 years of age or older) or disabled. On the other hand, less than 50% of Medi-Cal eligible persons are aged (65 years or older), blind, or disabled. In comparing the number of HHAs participating in Medi-Cal to the number of HHAs participating in Medicare, it is appropriate to consider the number of eligible persons in each program most likely to need HHA services. For purpose of this analysis, the target population of the Medicare program is all Medicare

[4] The Department does not have readily available data as to how many "users" of HCBS waiver services during 2001-2005 received services from specific provider types, such as HHAs, INPs, or PCSPs.

eligible persons in California, and the target population of the Medi-Cal program is all Medi-Cal eligible beneficiaries who are either aged, blind, or disabled.[5]

Table 2 below shows the data considered for this analysis.

Medicare & Medi-Cal Enrollment Summary								
Year	HHA Medicare CA Providers[1]	HHA Medi-Cal Providers[2]	Total Medicare Enrollees[3]	Total Medi-Cal A&D Eligibles[4]	Medicare Enrollees per HHA Provider[5]	Medi-Cal A&D Eligibles per HHA Provider[5]	# of Medicare Providers per Enrollee[6]	# of Medi-Cal Providers per A&D Eligible[6]
2001	504	419	3,947,000	1,416,368	7,831	3,380	0.00013	0.00030
2002	530	427	4,004,000	1,487,080	7,555	3,483	0.00013	0.00029
2003	599	415	4,066,000	1,572,926	6,788	3,790	0.00015	0.00026
2004	632	396	4,122,332	1,608,943	6,523	4,063	0.00015	0.00025
2005	637	449	4,200,640	1,652,657	6,594	3,681	0.00015	0.00027

[1] California home health agency Medicare provider counts are based on the number of unique provider numbers that filed a Medicare cost report with a year overlapping the calendar year.

[2] Medi-Cal home health agency provider counts are based on the number of unique Medi-Cal provider numbers that submitted Medi-Cal home health claims with a beginning date of service during the calendar year.

[3] Medicare enrollee soure: CMS website, "Total Resident Population of the US, Total Medicare, by State of Residence charts" (table 10 for years 2001-2003); "Medicare Enrollment: Hospital Ins. (HI) and/or Supplementary Medical Insurance for Aged & Disabled (A&D) Enrollees & Total Resident Population by State of Residence" (Table 2.8, 2006 & 2007 charts include data used for 2004 and 2005). The charts may be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/index.html

[4] This represents the number of certified Medi-Cal eligible beneficiaries who are aged (65 years and older), disabled, or blind as of July of each calendar year according to the Monthly Medi-Cal Eligibility File. This includes such beneficiaries in both the Medi-Cal fee-for-service system and enrolled in a Medi-Cal managed care plan. A certified eligible beneficiary is a person with no unmet share of cost obligation.

[5] Medicare enrollees per HHA provider is the total number of Medicare enrollees divided by the number of HHA Medicare CA providers. Medi-Cal A&D eligibles per HHA proveders is the total number of Medi-Cal A&D eligibles divided by the number of HHA Medi-Cal providers.

[6] The number of Medicare providers per per Medicare enrollee is the number of HHA CA Medicare providers divided by the total number of Medicare enrollees. The number of Medi-Cal providers per A&D Medi-Cal Eligible is the number of HHA Medi-Cal providers divided by the total number of Medi-Cal A&D eligibless.

[5] Because some Medicare beneficiaries may be enrolled in Medicare managed care plans, this analysis includes the number of all Medi-Cal eligible aged, blind, and disabled persons, both those in the fee-for-service system and those enrolled in a managed care plan.

Table 2 shows that for all five years, there were more Medicare beneficiaries than Medi-Cal eligible aged, blind, and disabled beneficiaries. This data supports the fact that there was a need for more HHA providers in Medicare than Medi-Cal because there were more Medicare beneficiaries than Medi-Cal beneficiaries likely to need HHA services. Thus, in 2001, there were 7,831 Medicare beneficiaries for each Medicare HHA and 3,380 aged, blind, or disabled Medi-Cal beneficiaries for each Medi-Cal HHA. This explains why there would be more Medicare providers as compared to Medi-Cal providers during this period.

Table 2 further shows that there were more HHAs participating in the Medi-Cal program per each member of the Medi-Cal eligible target population (e.g., aged, blind, and disabled), than the number of HHAs participating in the Medicare program per each Medicare eligible person. For example, in 2001, there were .00030 Medi-Cal HHAs per Medi-Cal beneficiary in the target population compared to only .00013 Medicare HHAs per each Medicare beneficiary.

In summary, the Department has determined based on the data in Table 2 that Medi-Cal beneficiaries had access to HHA services that was at least as good as that available to Medicare beneficiaries during 2001-2005. Moreover, DHCS has concluded that the expanded home services available to Medi-Cal beneficiaries under the HCBS waiver program provides Medi-Cal beneficiaries with more options for in-home health care services than exist under the Medicare program.

III

CONCLUSION

The percentage of HHA users out of the Medi-Cal fee-for-service eligible population during 2001-2005 was favorable when compared to the percentages during the 1992-1997 period considered in the 1998 study, which determined there was sufficient access. The percentages are even better when one considers the various non-rate factors that likely contributed to fewer HHA users in 2001-2005, including an increase in ADHCs, new provider types such as pediatric day care facilities and INPs, and changes in the HCBS waiver program.

There was an unexplained fluctuation in the number of HHA "users" between 2003 and 2005, but the Department does not believe this is related to any problem with reimbursement rates paid to HHAs, because other indicia of HHA participation in Medi-Cal increased during this period. The number of HHAs participating in the Medi-Cal program increased steadily by 7% from 419 in 2001 to 449 in 2005. And the participating HHAs provided an increasing volume of services to Medi-Cal beneficiaries. Specifically, HHAs provided more units of service in 2005 than 2003 and Medi-Cal paid HHAs $3.9 million more in 2005 than in 2003. The Department believes the

fluctuation in the average monthly "users" within the 2001-2005 period is related to the availability of other health care options, some of which were discussed in this report, that met the health care needs of beneficiaries who might otherwise need HHA services.

Finally, Medi-Cal beneficiaries had better access to HHA services than California Medicare beneficiaries. First, the number of Medicare beneficiaries for each Medicare HHA was higher than the number of Medi-Cal aged, blind, or disabled beneficiaries for each Medi-Cal HHA. Second, there were a higher number of providers for each Medi-Cal aged, blind, and disabled beneficiary than for each Medicare beneficiary.

For the reasons set forth above, the Department has determined that Medi-Cal beneficiaries had sufficient access to HHA services during 2001-2005 in accordance with section 1396a(a)(30)(A). Higher reimbursement rates for HHAs would not have been justified for this period to comply with section 1396a(a)(30)(A).

As Chief Deputy Director of Health Care Programs, I have the authority to approve and adopt this Department rate review on behalf of the Department's Director, and hereby do so.

March 14, 2013

Mari Cantwell
Chief Deputy Director of Health Care Programs
Department of Health Care Services