Department of Health Services
Rate Development Branch

TUCKER ALAN INC.
Home Health Agency Access Study

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MEDI-CAL HOME HEALTH SERVICES ACCESS STUDY

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EXECUTIVE SUMMARY

The State of California Department of Health Services ("DHS") has contracted with TUCKER ALAN INC. ("TUCKER ALAN") to conduct an access study, the results of which are presented in this report. The purpose of this report is to evaluate and compare the access to home health services of Medi-Cal beneficiaries and the general population in the State of California.

In order to complete this report, TUCKER ALAN:

- Examined the home health industry to identify the factors influencing its development and access by users of its services. This included a study of provider[1] requirements and reimbursement methodologies relating to the Medicare and Medicaid programs as well as recent legislative and regulatory changes affecting these programs.

- Interviewed officials at selected home health agencies throughout the State, representatives from the California Association for Health Services at Home (CAHSAH) and personnel at DHS. These visits were conducted in March and April of 1998.

- Evaluated available indicators of access to home health care for Medi-Cal beneficiaries.

Home health services are paid by a variety of sources, both public and private. Since most available data sources provide only Medicare and/or Medicaid specific information, it is difficult to estimate total home health expenditures. However, one estimate based on a nationwide survey projected $42 billion in home health care expenditures in 1997.[2] Home health agencies are typically highly dependent on Medicare reimbursement, since many of the patients receiving home care are over 65 years of age and/or disabled. Medicaid generally makes up a smaller percentage of an agency's funding. Managed care organizations are a growing private payor source for many agencies, as are commercial health insurance companies. Home health agency data for the State indicated that 81 percent of visits were paid by Medicare, 9 percent were paid by an HMO/PPO,[3] and 4 percent were paid by Medi-Cal in 1995.[4] Due to the dominance of Medicare as the primary payor of home health services, access to services for Medicare beneficiaries is an important indicator of general population access.

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[1] For purposes of this report, the term "provider" is used interchangeably with the term "agency".

[2] Basic Statistics About Home Care 1997, Table 6 (based upon National Medical Expenditure Survey data), The National Association for Home Care Web Page.

[3] Health Maintenance Organization/Preferred Provider Organization (HMO/PPO)

[4] Home Health Agency Annual Reports, 1995, Office of Statewide Health Planning and Development.

Utilization of the Medicare home health benefit has expanded greatly over the past ten years, largely due to major policy changes by the Federal government, as well as shifting demographics in the U.S. population. Within the context of expanding eligibility criteria and general liberalization of the program, Medicare payments to home health agencies have grown beyond expectation. Medicare payments for home health care rose from $3.9 billion in 1990 to $16 billion in 1995, and are projected to be greater than $20 billion for 1997.[5] In 1996 and 1997, the home health benefit represented about nine percent of total Medicare benefit payments.[6]

Over the past few years, Medicare's vulnerability to fraud and abuse stemming from the retrospective cost-based payment system has been recognized. The potential for fraud and abuse, along with increases in utilization and payments within the Medicare program, have resulted in closer examination of the home health benefit in an attempt to bring the program under control.

In response to the tremendous growth in Medicare expenditures, the Balanced Budget Act (BBA) was passed in 1997. The BBA required the implementation of an Interim Payment System that decreased the per-visit cost limit and established a per-beneficiary cost limit for Medicare reimbursement. In the State of California, the new legislation reduced the cost limit for skilled nursing by an average of 16 percent.[7] The BBA also authorized the Health Care Financing Agency (HCFA) to implement a Prospective Payment System on October 1, 1999. Furthermore, a 15 percent reduction in Medicare cost limits is required in Fiscal Year 2000, regardless of whether a Prospective Payment System is implemented by then. The BBA and other legislation imposed additional administrative requirements on providers that included obtaining a surety bond, satisfying revised conditions of participation pertaining to patient rights and providing outcome information such as the Outcomes and Assessment Information Set (OASIS).

The changes in Medicare rules and regulations were the predominant theme throughout our site visits with home health agencies. Providers were concerned about their ability to reduce costs below the new Medicare limits as well as satisfy the new administrative requirements. Another factor impacting their ability to serve home health users was the trend toward managed care contracts where the emphasis, similar to the new Medicare provisions, is on controlling costs and utilization. Although providers indicated that the recent legislative changes and trend toward managed care had not adversely affected Medi-Cal utilization, some acknowledged that further reductions in revenues may ultimately affect their ability to serve Medi-Cal beneficiaries in the future.

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[5] Basic Statistics About Home Care 1997, Table 8, The National Association for Home Care Web Page.
[6] Basic Statistics About Home Care 1997, Table 7, The National Association for Home Care Web Page.
[7] CAHSAH bulletin, February 13, 1998, Page 4.

In order to evaluate access to home health services by Medi-Cal beneficiaries, we analyzed various access indicators. These included the trend in Medi-Cal home health expenditures and users as well as the number of providers serving Medi-Cal beneficiaries in each county. This analysis indicated that over the last five years, home health expenditures more than tripled increasing from $17.6 million in 1992 to $61.9 million in 1997.[8] The growth in expenditures, users as a percentage of eligibles and expenditures per user paralleled the trend in Medicare home health expenditures over the same period. We found that the number of home health agencies providing at least 60 annual Medi-Cal visits as well as the number of Medi-Cal visits more than doubled between 1990 and 1995 which again paralleled the growth trend in Medicare agencies and visits. In addition, every county except one that reported home health visits in 1995 had one or more agencies providing at least 60 Medi-Cal visits. Based upon this review, we concluded that there is adequate access to home health services by Medi-Cal beneficiaries throughout the State.

One of the primary concerns voiced by agency officials during our site visits related to the Medi-Cal authorization process. Agencies were concerned that the actions of the field offices were inconsistent with policies issued by DHS. In addition, a common complaint of the agencies was that the field offices did not process Treatment Authorization Requests (TARs) in a timely manner. Our analysis of TAR data provided by DHS confirmed that the field offices had difficulty in processing TARs in a timely manner. However, based upon our analysis of access indicators, these concerns did not appear to have significantly affected access to home health services by Medi-Cal beneficiaries.

In addition to the above, our study indicated that recent legislative and regulatory changes in the Medicare program may result in decreased access by Medicare beneficiaries, at least for the short-term, due to the provisions of the Balanced Budget Act of 1997. From our examination of the home health industry and our site visits, it is apparent that the industry is undergoing significant changes in response to the new provisions. Since Medicare is the primary payor of home health services, it is expected that most providers will be forced to cut costs and become more efficient as they struggle to meet the new administrative requirements with decreased revenues. Although it is too early to quantify the effect on Medi-Cal beneficiaries from these changes, our site visit discussions did not indicate an adverse effect at this time. However, over the long term, providers that do not adapt their operations to the efficiencies required by the Medicare program may be forced to close. Such closures may impact access to home health services for all users, including Medi-Cal beneficiaries, in the State of California.

[8] Medi-Cal Services and Expenditures Month-of-Payment Reports for Calendar Years 1992-1997.

1. INTRODUCTION

The purpose of this report is to evaluate and compare the access to home health services of Medi-Cal beneficiaries and the general population in the State of California. Users of home health care can be identified by the payor of the services provided. Although total home care spending is difficult to estimate, one estimate indicated that Medicare was the largest single payor of home health care services in 1995, representing approximately 50 percent of home care expenditures nationwide.[9] In the State of California, Medicare was the primary reimbursement source for 81 percent of home health visits reported by licensed home health agencies in 1995. Other significant payor types in California in 1995 included HMO/PPO (9 percent of visits) and Medi-Cal (4 percent of visits). Due to the dominance of Medicare as the primary payor of home health services, access to services for Medicare beneficiaries is an important indicator of general population access.

The home health industry is currently undergoing dramatic national changes. Factors that are significantly affecting the industry include changes in the Medicare reimbursement system and administrative requirements, as well as the increased trend towards managed care. The steps performed to complete this report fall into three general areas. First, an examination of the home health industry was conducted to identify the factors influencing its development and access by users of its services. This included a study of provider requirements and reimbursement methodologies relating to the Medicare and Medicaid programs. Recent legislative and regulatory changes for these programs were also evaluated. Although this report focuses on the Medicare and Medi-Cal fee-for-service programs, information about managed care programs is presented when available. Second, visits were made to selected home health agencies throughout the state, as well as with representatives from the California Association for Health Services at Home (CAHSAH) and personnel from the State's Department of Health Services (DHS) to develop a comprehensive perspective of issues relating to the home health industry. Finally, various statistical indicators of access including the trend in home health expenditures over time and the number of agencies serving Medi-Cal beneficiaries were analyzed. The results of this work are discussed in this report.

The report is organized as follows:

- Chapter 2 provides a historical overview of the home health industry focusing on industry growth and consolidation, managed care participation, and efforts to control fraud and abuse.

[9] Basic Statistics About Home Care 1997, Table 6 (based upon National Medical Expenditure Survey data), The National Association for Home Care Web Page.

- Chapter 3 describes the requirements that home care providers must meet to participate in the Medicare and Medicaid programs and the home health benefits generally provided under these programs. In addition, it discusses recent legislative and regulatory changes that have impacted these requirements.

- Chapter 4 provides a description of the current reimbursement methodologies employed under the Medicare and Medicaid programs, as well as managed care contracts. It also discusses recent legislative and regulatory changes that have impacted reimbursement in these programs.

- Chapter 5 summarizes the results of the site visits to selected home health agencies in California.

- Chapter 6 presents an evaluation of indicators of access to home health services for Medi-Cal beneficiaries.

- Chapter 7 provides a summary of our findings.

2. HISTORICAL OVERVIEW OF THE HOME HEALTH INDUSTRY

Home health care has been in existence since the late 1800s when the Visiting Nurse Associations began operations. The passage of the Social Security Act in 1965 established Medicare, under which home health care was provided as a benefit to eligible persons. Although home health benefits were optional under Medicaid at the time of its passage in 1965, home health became a mandated Medicaid benefit in 1971.

Home health care includes a variety of service lines, from intermittent care, hospice, and private duty to home infusion therapy, home medical equipment and various types of specialty skilled nursing. The home health care industry has grown significantly since its inception reaching an estimated $42 billion in expenditures or 4 percent of national health care spending and 7.4 million recipients nationwide in 1997.[10] To gain an understanding of the home health industry, the following topics were studied: Industry Growth, Industry Consolidation, Managed Care Participation, and Recent Efforts to Control Fraud and Other Abusive Practices.

Growth in the Home Health Industry

Growth in the use of home health services during the 1970s and 1980s was mainly due to the expansion of the home health benefit through legislative changes. Significant changes included the Social Security Amendments of 1972 and the Omnibus Reconciliation Act of 1980 (OBRA).

OBRA contained the following major revisions to the home health benefit:

- Elimination of the three-day prior hospitalization requirement as a condition for the receipt of home health services under Medicare Part A.
- Elimination of the requirement to meet the Part B deductible before Medicare payments for home health services under Part B could be initiated.
- Elimination of the 100 visits per year limit on home health visits.
- Allowed proprietary home health agencies to furnish Medicare covered services in states not having licensure laws.

The effect of these expansions to the Medicare home health benefit was to liberalize the coverage provisions and loosen the linkage of home health services to the treatment of acute illnesses. In short, home health services became increasingly viewed as an alternative to

[10] NAHC Projections, Basic Statistics About Home Care 1997, pages 4 and 9, The National Association for Home Care (NAHC) Web Page.

institutional forms of care, as well as a significant stage in the continuum of care following hospitalization. The passage of OBRA thus increased the population eligible under Medicare as well as the number of agencies allowed to provide services. In addition, in 1988 the Duggan v. Bowen decision expanded Medicare coverage by relaxing the definition of "part-time or intermittent care."

These legislative changes and others led to the boom in the industry in the 1980s which has continued into this decade. The increase in home health expenditures and the number of providers demonstrate the significant growth in this industry nationwide over the past decade. In addition, the shift in demographics in the U.S. population and advances in technology have likely contributed to growth in the home care industry.

- Home Care Expenditures

  Home health care expenditures increased approximately 50 percent from $28.6 billion dollars in 1995[11] to $42 billion nationwide in 1997. Medicare is the largest payor of home health services, accounting for almost half of national home care expenditures. Medicare home health agency benefits payments have more than quadrupled in the 1990s, rising from $3.9 billion in 1990 to $20.5 billion in 1997.[12] During the last decade, home health expenditures were one of the fastest growing components of the Medicare program. This growth can be attributed to the increase in the number of visits per beneficiary, the growth in the number of beneficiaries using home health services and the growth in the number of home health providers.

- Number of Home Health Agencies

  In 1996, it was estimated that there were nearly 20,000 home health care organizations nationwide, including approximately 10,000 Medicare-certified home health agencies.[13] The number of agencies certified to participate in the Medicare program nearly doubled between 1967 and 1980, and then nearly doubled again from 1980 to 1985. In the mid-1980s, the number leveled off as a result of increasing Medicare paperwork and unreliable payment policies. In 1987, a coalition of U.S. Congress members, consumer groups and the National Association for Home Care (NAHC) brought a lawsuit against HCFA, resulting in a rewrite of the Medicare home care payment policies. After these revisions, Medicare's annual home health benefit outlays increased significantly and the number of home care agencies rose from approximately 5,900 in 1985 to 20,000 in

[11] CCH Home Care Provider's Guide, Report 21, March 1997, page 7.
[12] Basic Statistics About Home Care 1997, Table 8, The National Association for Home Care Web Page.
[13] Ibid., Table 1.

1996.[14]

- Shift in Demographics

  The Medicare-age population is increasing, as is the average age of older Americans. A National Center for Health Statistics study released in 1995 indicated that over 66 percent of Medicare home health beneficiaries were 75 years of age or over, and more than 20 percent were 85 or older. Of the total home health visits provided in California in 1995, 68 percent were provided to persons over the age of 70. Population projections by the Social Security Administration estimate that the population of those age 65 and over will increase from 34.2 million in 1995 to 35.4 million in 2000, an increase of 3.5 percent.[15]

- Effect of Medical Advances

  Advances in technology have substantially increased the services that can be provided in-home. Procedures that were once performed only on an inpatient basis can now be shifted to outpatient care, with the availability of additional care from other health care facilities. Recent technological advances have made complex medical equipment more compatible with the home environment. This has extended the boundaries of what is technically feasible, affecting both the organization and delivery of home health services in terms of staffing, medical coordination, education, and ancillary services.

Industry Consolidation

In response to changes in the Medicare program and health delivery system, home health providers have adapted their organizational structures to be competitive in this market. Organizational changes among home health agencies were widespread by the mid-1980s. Agencies formed new configurations to merge into hybrid and multidivisional entities. Agencies also added non-Medicare branches and divisions, sometimes comprised of multiple entities of varying tax statuses, spun off new product lines, established formal relationships with complementary organizations, and bought and sold other health entities.

The number of home health agencies remained stable throughout the 1970s. Federal restrictions initially allowed only public and not-for-profit home health agencies to participate in Medicare until 1980. With the passage of OBRA, which permitted the certification of for-profit home health agencies in states not having licensure laws, the number of home health agencies increased.[16] The subsequent growth in the number and proportion of for-profit agencies in the

[14] Ibid., Pages 1 and 2.
[15] HCFA Web page statistics, 1996
[16] 1996 Statistics at a Glance, Pages 1-2, Health Care Financing Agency Web Page.

1980s, from 471 in 1982 to 1,904 (nearly one third of all agencies) in 1986, reversed a 20-year pattern of dominance by not-for-profit agencies.[17]

Growth since the 1980s has primarily taken place in for-profit agencies, while the percentage of more traditional not-for-profit home health providers (visiting nurse associations and government agencies) has declined. In 1996, nearly 50 percent of Medicare-certified home health agencies represented for-profit agencies.[18]

The increase in proprietary home health agencies may continue, even given the current turmoil in the industry. Consolidation is occurring among the larger health care organizations, who are also purchasing the smaller freestanding agencies.

Managed Care

The concept of managed care originated as a means to lower health care costs by better "managing" the care provided. For example, as organizations strive to lower costs, they look at shortening or eliminating expensive hospital stays and shifting care to less expensive outpatient and home care options. Health maintenance organizations stress preventive care, and impose limits on the types of care that can be provided for specific health problems. In the case of home health care, these organizations typically limit the number of visits that are approved for a patient, allowing for fewer visits than the patient would have received under fee-for-service health care plans. Both Medicare and Medicaid are implementing managed care models. Managed care can be subdivided into several categories that are discussed below.

- Medicare Managed Care Contracts - As of January 1, 1997, 13 percent of Medicare beneficiaries nationwide received coverage under managed care programs.[19]

- Medicaid Managed Care Contracts - Managed care contracts are being implemented around the country, in practically every state. In 1996, one of every three Medicaid recipients was covered nationwide under a managed care program.[20] California is phasing in its Medi-Cal managed care program which will cover mainly the AFDC population.

- Commercial HMO/PPO Contracts - Many large commercial managed care organizations exist. These managed care organizations have a growing role in the healthcare industry. Larger national managed care organizations have often favored

[17] Estes, Carroll, Swan, James, Bergthold, Linda, Spohn, Pamela, "Running As Fast as They Can: Organizational Changes in Home Health Care", p. 42.
[18] Basic Statistics About Home Care 1997, Table 2, The National Association for Home Care Web Page.
[19] Ibid., Page 9.
[20] Ibid.

contracting with larger national home care providers (such as Olsten Kimberly Quality Care, Apria, Interim and Staff Builders). These chains provide the "one-stop shopping" and geographic coverage that regional or freestanding home care agencies cannot.

Recent Efforts to Curb Medicare Fraud and Other Abusive Practices

Because of the high growth in home health utilization and expenditures under Medicare as discussed above, the industry has gained the attention of fraud and abuse efforts. Operation Restore Trust (ORT) is a joint effort involving the Office of the Inspector General, HCFA and the Administration on Aging that was launched in May 1995. ORT targets areas of high spending growth, including home health care, nursing homes, and durable medical equipment providers. Overall, ORT has identified almost $188 million owed to the federal government in its first two years as a demonstration project.[21] The demonstration project was represented in five states including California. In the home health care industry, ORT audits have reported HHA denial rates as high as 25 to 30 percent of all Medicare claims.

The Kasselbaum-Kennedy Health Insurance Portability & Accountability Act of 1996 strengthened federal efforts to curb fraud and abuse in the home health industry. It provided for expansion of the ORT into a nationwide program. In addition, it focused on involving physicians and beneficiaries in reporting unscrupulous behavior.

From September 1997 to January 1998, the federal government imposed a moratorium on the certification of new home health agencies for Medicare. The intent of the moratorium was to prevent fraudulent providers from entering the Medicare home care arena while new protections were put in place. This action, along with other recent changes in the Medicare program, virtually halted entrance into the industry. During the period from October 1997 to April 1998, the State of California's Licensing and Certification Division made only twelve initial Medicare licensing visits as compared to 50 the previous year.

Balanced Budget Act of 1997 (BBA)

In response to the tremendous growth in Medicare expenditures over the last decade, the Balanced Budget Act was passed in 1997. This act imposed a number of new requirements on Medicare home care providers and revised the method of reimbursement. The changes generated by the BBA were described as "the most significant in the history of Medicare" by Linda Ruiz, Director of Program Integrity, HCFA.[22] The Congressional Budget Office estimated that the BBA would result in savings of $16.2 billion over five years in the area of home health

[21] Secretary Shalala Launches New "Operation Restore Trust", HCFA Web Page.
[22] Testimony on "Fraud and Abuse in Home Health Care", House Committee on Commerce, October 29, 1997.

alone.[23] These changes may have significant impact on the access of Medicare beneficiaries to home health services. Provisions of the BBA affecting access to home care services are discussed in Chapters 3 and 4.

[23] Smith, Sheila, "The Balanced Budget Act of 1997: Implications for Health Providers", Standard & Poor's DRI Health Care Cost Review, Third Quarter 1997.

3. PROVIDER REQUIREMENTS

The requirements for the Medicare and Medi-Cal programs, both in terms of how an agency becomes eligible to provide home health services and how a beneficiary becomes eligible to receive home health care, are described in this Chapter. In addition, managed care contracts and programs are discussed.

Medicare

Overall, about 10 percent of all Medicare beneficiaries received home health services in 1996.[24] To receive Medicare coverage for home health services, the beneficiary must be confined to the home, be under the care of a physician who prescribes home care, and require either intermittent skilled nursing services or physical or speech therapy. There is no prior hospitalization requirement for coverage. In addition, there is no beneficiary deductible or co-payment requirement for home health care. Under the Balanced Budget Act of 1997, a study of the definition of "homebound" used in determining eligibility for Medicare home health coverage is expected to be presented to Congress by October 1, 1998.

To be Medicare certified, providers must meet the Medicare conditions of participation, which include providing certain required home health services, being licensed, and maintaining various policies and procedures. Recent proposed changes to the Medicare conditions of participation focus on expected patient-centered outcomes of Medicare services include the following requirements:[25]

- Patient rights requirements: Requires that patients be informed about expected outcomes and barriers in their treatment.

- Comprehensive assessment: Requires timely assessments that identify patients' needs and ensure that this critical information is routinely considered.

- Patient care planning and coordination: Simplifies requirements and focuses on requiring prompt communication of changes in patient care plans.

- Quality assessment and performance improvement: Requires agencies to develop and implement quality and performance improvement programs. A related rule requires agencies to electronically file data from the Outcomes and Assessment Information

[24] Prospective Payment Assessment Commission Report and Recommendations to the Congress, March 1, 1997, CCH Inc., Page 1.

[25] CCH Home Care Provider's Guide, Report 21, March 1997, Page 1.

Set (OASIS) beginning in 1999. This data set includes numerous indicators related to home health care outcomes, such as demographics, living arrangements, sensory status, respiratory status, activities of daily living and medications, among others.

Other new conditions that an agency must initially meet to become Medicare-certified include:

- *Surety Bonds.* To participate in the Medicare program, a home health provider must obtain a surety bond for the greater of $50,000 or 15 percent of the prior year's Medicare revenues. Originally, the Medicare surety bonds were required to be in place by January 1, 1998, and submitted to HCFA by February 27, 1998. On February 26, 1998, HCFA published a letter removing this deadline until 60 days following the publication of a final rule regarding the surety bonds. The Grassley & Breaux Bill[26], titled the Home Health Integrity Preservation Act and introduced in the Senate in May 1998, proposes to require surety bonds of $25,000 only for agencies applying to Medicare, rather than those already qualified.

- *Initial capitalization.* Agencies that wish to become Medicare certified must establish an initial operating fund equal to three months of the agency's operating costs (as determined by the fiscal intermediary).

- *Service Level.* Agencies that wish to become Medicare eligible must provide service to at least ten patients.

Medi-Cal

Medi-Cal is a State program designed to provide basic medical coverage, including home health services, to low income persons and is substantially funded by Medicaid. In general, Medi-Cal covers families, children and pregnant women, aged, disabled and blind persons. Less than one percent of Medi-Cal beneficiaries receive home health services where Medi-Cal is the payor.[27] This does not include those Medi-Cal beneficiaries, who are dually eligible for Medicare, whose home health expenditures are predominantly reimbursed through Medicare.

In order to receive reimbursement under the Medi-Cal program, home health agencies must be Medi-Cal certified. In general, the certification requirements are the same as those for Medicare, except for the newly implemented Medicare Surety Bond and capitalization requirements. There is a recent requirement for home health agencies to obtain a surety bond to protect Medicaid as well; however, most states, including California, have not yet implemented this requirement. As

[26] CCH Home Care Provider's Guide, Issue 35, May 1998, Page 1.
[27] Medi-Cal Services and Expenditures Month-of-Payment Report for Calendar Year 1997.

such, DHS is in the process of drafting regulations regarding the Medicaid surety bond requirement; however, the timeline for implementing these regulations is unclear.

To operate in the State of California, all public or private organization providing skilled nursing services to persons in their temporary or permanent place of residence must obtain a license. Exceptions to the Home Health Agency licensing rules include entities that function only as an employment or temporary staffing agency, or that provide only personal care services or home medical equipment; California does not require these providers to be licensed.

Managed Care

The increasingly competitive health care market has created incentives for home care agencies to enter managed care provider networks. Managed care organizations will contract either directly with home health agencies, or with a hospital or a physician who in turn contracts with the home health agency in order to provide a broad spectrum of care. The requirements for each managed care organization vary. Currently, both the Medicare and Medi-Cal programs are moving to cover increasing numbers of beneficiaries under managed care programs.

4. REIMBURSEMENT METHODOLOGIES

This section describes how providers are reimbursed for delivering home health services under Medicare, Medi-Cal and managed care programs and describes the changes in reimbursement mandated by the BBA.

Medicare

Balanced Budget Act: Interim Payment System

Currently, home health agencies are reimbursed on the basis of agency-specific costs, subject to a limit. The BBA dramatically changed reimbursement limits for home health agencies under Medicare. Among the provisions under this legislation is the implementation of a new Interim Payment System which reimburses agencies at the lowest of the following[28]:

- (1) Actual costs.
- (2) Per-visit cost limits. The cost limits are reduced from 112 percent of the mean average cost to 105 percent of the median average cost of freestanding home health agencies. These new limits are based on costs primarily from Federal Fiscal Year 1993, updated for inflation through Fiscal Year 1999, but not including Fiscal Years 1994 and 1995. This is effective for Medicare cost reporting periods beginning on or after October 1, 1997. It is estimated that this will result in a 16 percent reduction in the Medicare cost limit for skilled nursing in California.[29]
- (3) A blended, agency-specific per-beneficiary limit based on 98 percent of 1994 costs. Seventy five percent of the blended limit is based on 98 percent of an agency's reasonable costs for the 12-month cost reporting period ending in 1994, with the remaining 25 percent based on 98 percent of the standardized regional average of these costs in the agency's census region. This limit is multiplied by the agency's Medicare population to derive the payment amount.

Balanced Budget Act: Prospective Payment System

The Balanced Budget Act also authorizes HCFA to implement, for cost reporting periods beginning on or after October 1, 1999, a Prospective Payment System, which is a totally new

[28] Paragraph 804 of the Balanced Budget Act of 1997.
[29] CAHSAH bulletin, February 13, 1998, Page 4.

payment strategy that is prospective and episodic in nature. While the final prospective payment system model has not yet been approved, it will have predetermined payment levels that are not influenced by an agency's actual costs. In this environment, providers will be able to realize profits or losses depending on how their cost structure relates to the set rates. The BBA requires the Prospective Payment System to include a case-mix adjustment.

Balanced Budget Act: Other Provisions

The BBA also contained the following provisions:

- Eliminates home health benefits based solely on drawing blood (venipuncture), effective February 5, 1998.

- Imposes an additional 15 percent reduction in cost limits and per beneficiary limits for FY 2000, regardless of whether the Prospective Payment System is implemented by October 1, 1999.

The change in the payment methodology imposed by the BBA is part of an effort to control the frequency and duration of care, thus reducing total home health expenditures. The Visiting Nurse Association of America worked with legislators to introduce a bill that would increase reimbursement to levels existing before this system was introduced. The bill[30], titled the Medicare Home Health Equity Act of 1998, was introduced at the House level in March 1998 and was co-sponsored by Mike Pappas of New Jersey and six other Congress members. A similar bill was sponsored by Senators John Chaffee and Susan Collins and introduced in the Senate in May 1998.

Medi-Cal

Under Title 22 of the California Code of Regulations, Medi-Cal sets reimbursement rates for specific home health services, including skilled nursing, home health aides and therapists. The program establishes per-visit allowances for services provided and sets prior authorization requirements and limits on the frequency of certain types of visits. For example, one initial case evaluation and treatment plan visit is allowed during a six month period and one monthly case evaluation visit is allowed per month. Prior authorization is not needed for the initial case evaluation visit or the monthly case evaluation visit. For the remaining services, prior authorization is required, except when the visit is performed in conjunction with the initial case evaluation, and there is no limit on frequency as long as visits are pre-approved. Historically, Medi-Cal rates have been lower than Medicare's, but the gap has narrowed due to the reductions imposed by the BBA.

[30] H.R. 3567.

Managed Care

Under commercial managed care programs, reimbursement is based upon a prepaid rate for a defined set of services. While home health benefits are provided under commercially available managed care, these contracts do not generally allow as many visits as fee-for-service payor sources. The emphasis is on providing care in the most cost-effective manner. This may result in greater utilization of home care for patients with illnesses that might previously have been treated on an inpatient basis and lead to increased costs for home health agencies to treat sicker patients. For hospital-based agencies, this increased cost is offset by lower costs on the hospital side, which may result in overall benefits to the parent organization, the hospital. However, freestanding home health agencies in managed care capitation contracts may incur increased cost per patient that cannot be offset by additional fees for those patients who are more seriously ill.

CHARACTERISTICS OF AGENCIES VISITED

Agency	Geographic Coverage (Counties)	Ownership	Structure	Total Visits (most recent year available)	Percent of Visits			
					Medicare	Medi -Cal	Managed Care	Other
California Health Professionals	Chico	For Profit	Freestanding	60,000 (FY 97)	96	2	-	2
Scripps-Mercy Home Health Care	San Diego	Not-for-Profit	Hospital-Based	180,000 (FY 97)	76	3	20 (11 percent is capitated)	1
Sun Plus Home Health Services	Seven counties in the Bay Area and Northern California, south to Ventura	For Profit	Freestanding (Affiliated with Nursing Home Chain)	>400,000 (based on VNA LA and Care Home Health in FY 95)	75	10	15	-
UCSD Home Care	San Diego	Not-for-Profit	Hospital-Based	72,000 (FY 96)	56	20	8	16
UCSF Mt. Zion Home Care	San Francisco	Not-for-Profit	Hospital-Based	60,460 (FY 95)	79	12	1	8
Visiting Nurse Association of the Inland Counties	Riverside, San Bernardino	Not-for-Profit	Freestanding	130,000 - 140,000 (FY 97)	74	3-4	22-23	-

General Comments

Opinions Shared by All Providers

A consistent complaint voiced by providers we visited was related to the time and paperwork involved with the Medi-Cal Treatment Authorization Request ("TAR"). The outcomes of TARs submitted by home health agencies and the time spent by the Medi-Cal field offices to process the TARs are analyzed in Chapter 6. The State has implemented two initiatives to help providers to get TARs approved in a timely and reasonable manner. These are the Discharge Planning Option and the Medical Case Management programs. In general, providers thought these programs are both good options, but that they are not broad enough in scope.

- Discharge Planning Option (DPO)

  The DPO program is designed to pre-approve home health services for Medi-Cal beneficiaries who are discharged from an acute care facility and need short-term home health care. The Medi-Cal nurse visits the patient in the hospital and writes a "DPO TAR" which alleviates the provider's need to submit a TAR to the field office. The providers visited felt that this initiative was working well. The only criticism that we heard about the DPO was from UCSD. They felt that it is difficult to utilize this option, because the TAR must be approved before the patient leaves the hospital. In addition, it is difficult to know exactly what care is required before observing the patient in the home.

- Medical Case Management (MCM)

  The MCM program covers complex Medi-Cal patients. This program applies to all complex patients, not only those with recent hospital stays.[32] In general, the agencies think the MCM program works extremely well. Many expressed the desire to expand this program to cover other types of patients, not just complex cases. Several agencies noted that it would be useful if the guidelines used for the MCM program were applied more generally to the TAR approval process.

With regard to the BBA, all of the providers reported that Medicare visits comprised more than 50 percent of their total visits and indicated that their revenues have been or will be significantly reduced as a result of the Interim Payment System. Not only have the rates per visit decreased, but total visits have dropped as providers strive to remain below the per beneficiary limits. To remain competitive, providers are implementing steps to reduce their costs such as decreasing training or placing limits on travel distances for a single visit. Other more drastic changes such as an organizational re-structuring may be implemented if Medicare reductions continue.

[32] Medical Case Management Program Fact Sheet, dated May 1997, DHS Website.

Another general opinion shared by the providers we interviewed was that they hope to survive difficult financial times, and to pick up market share when others drop out of the market. Most providers we talked to believed that the smaller agencies will eventually close, enabling existing providers to add to their patient base.

With regard to managed care, the providers we spoke with in urban areas were more likely to have managed care contracts. Most appear to be working primarily with physician groups or hospitals that have already contracted with managed care organizations, rather than direct contracting themselves. In general, managed care rates vary depending on the contract. The providers we interviewed have not generally found managed care contracts to be lucrative reimbursement sources. Providers stated that many agencies had accepted capitated rates which they later discovered were too low to cover their costs. Rates that agencies are willing to accept depend on the expectation of patient volume, and the importance of the managed care payor in terms of geographic coverage and as a referral source. In addition, home health agencies may feel obligated to service commercial managed care contracts in order to remain competitive.

Opinions Shared by Hospital-Based Agencies

Two of the three hospital-based agencies we spoke with had undergone recent mergers with other large institutions. Affected by reimbursement cuts, hospital-based agencies are no longer viewed by their parent hospitals as revenue generators, but are now considered cost centers. Hospital-based agencies tended not to attempt to limit the number of Medi-Cal referrals they accepted, but they also view themselves as "dumping grounds" for Medi-Cal patients. Hospital-based agencies we spoke with believe they will survive in the long run due to their extensive financial support system.

Opinions Shared by Freestanding Agencies

The freestanding agencies we interviewed were concerned with finding and retaining referral sources. These providers are willing to take Medi-Cal patients in order to maintain a strong referral source, as it is generally more difficult to obtain referrals as a freestanding non-affiliated agency. However, two of the three freestanding agencies we visited mentioned that they place limits on the number of Medi-Cal referrals they accept.

The remainder of this section provides detailed summaries of the relevant points made by each provider visited.

California Health Professionals (CHP)

At the time of our visit, California Health Professionals was in the process of transitioning its intermittent patients to another agency, Home Health Care Management. Home Health Care Management had previously provided only private duty and shift care; this agency was Medicare certified, but was not serving Medicare patients. CHP had determined that they would be better off financially under the Interim Payment System if they were able to transfer all of their intermittent patients to another agency. Currently, the owner of CHP is financing its operations; the agency may close if financial conditions do not improve.

In addition, fraud and abuse control efforts have greatly impacted California Health Professionals. In June 1996, CHP was the subject of an Operation Restore Trust survey which interfered with its JAHCO certification and resulted in a corrective action plan to correct for several deficiencies. The corrective action plan ultimately increased costs by requiring additional staff training. The investigation of this agency has caused a multitude of problems related to staffing, legal fees, time spent dealing with investigators and appealing denied claims under Medicare.

CHP was the most rural of the agencies we visited, and covers geographic areas that have limited access to home health care in general.

- *Impact of Balanced Budget Act*: CHP will not be affected by the Interim Payment System until October 1998, but 1996 Medicare cost limits cut its reimbursement by 20 percent. The agency estimates that the Interim Payment System could result in a 50 percent reduction in reimbursement and is currently taking steps such as changing its organizational structure to mitigate this impact.

- *Surety Bond Impact*: CHP has obtained several bonds for various branches, but feels it cannot afford to get a bond for each subunit.

- *Participation in Managed Care Contracts*: CHP has been offered contracts at rates lower than Medi-Cal, which have not been accepted. It does not participate in substantive managed care due to its rural nature.

- *Access Issues*: CHP voiced several concerns mainly related to its rural characteristics:

    - Rural home health agencies are impacted more significantly by the change in venipuncture coverage under Medicare. Labs will not travel distances to draw blood, so patients who should be monitored may no longer get this level of care. CHP stopped providing services to twelve patients who had previously been covered by Medicare.

- Some rural areas have limited or no access to any home health services due to a lack of agencies, or because agencies are not willing to take patients in distant or remote areas. For example, CHP was asked to take Medi-Cal and other patient referrals in Elk County, but declined.

- *Medi-Cal Program Issues*: CHP believe that its TARs are denied inappropriately, especially in the case of psychiatric patients and Board and Care Facility residents who require home health aide services. The agency feels this is due to inconsistencies between written policy and field office implementation.

- *Cost Structure*: CHP has 60 percent direct costs, 10 percent taxes and benefits and 30 percent administrative costs.

Scripps-Mercy Home Health Care (Scripps)

Mercy Home Health has recently merged with Scripps. This was one of several San Diego-based agencies we visited. Seventy percent of Scripps' referrals come from its hospitals, including managed care contracts. This agency provided a positive response to Medi-Cal rates, compared to other current payor options.

- *Impact of Balanced Budget Act*: Scripps is expecting a significant loss under the Interim Payment System; it estimates a reimbursement decrease of 20 percent. However, at present, its costs will remain under the Medicare limits.

- *Surety Bond Impact*: Scripps does not foresee a problem obtaining the bonds if and/or when they are actually required, given the capital available from its hospitals.

- *Participation in Managed Care Contracts*: Scripps has had experience with capitated managed care contracts. In some cases, these contracts have provided reimbursement less than Medi-Cal rates.

- *Access Issues*: Scripps appeared to be open to taking as many Medi-Cal patients as possible, and management did not mention any major issues with the Medi-Cal program.

- *Medi-Cal Program Issues*: TARs are generally approved. Scripps indicated problems with the timeliness of the process, as it often has completed care before receiving approval from the field office.

- *Cost Structure*: 62 percent direct costs.

Sun Plus Home Health (Sun Plus)

The Visiting Nurse Association of Los Angeles has recently been purchased by Sun Plus, as part of Sun Plus' purchase of Regency Health Care. Sun Plus is owned by a parent corporation in New Mexico which owns numerous long-term care and several acute care facilities. Sun Plus has only expanded into home health care in the past five years. Currently, about 20 percent of its referrals come from its long-term care facilities. Other referrals come from physicians and hospitals.

- *Impact of Balanced Budget Act*: Sun Plus' costs remain under the Medicare limits under the Interim Payment System. Currently, it receives an average of about $90 to $95 per visit under Medicare, compared to an estimated $80 breakeven cost.

- *Surety Bond Impact*: Sun Plus does not view this issue as problematic due to a well capitalized organization.

- *Participation in Managed Care Contracts*: Sun Plus has turned down managed care contracts that offered low rates; most recently it rejected a fee schedule offering $63 per visit. Sun Plus stated it would reject any managed care contracts that were below Medi-Cal rates but believes that its competitors will actively accept these lower rates.

- *Access Issues*: Sun Plus attempts to limit the number of Medi-Cal patients accepted. This limit is set on an individual branch basis. The main factor in this decision is the strength of the referral source, and the potential for generating referrals for patients linked to other payor types. Sun Plus is still associated with the VNA of Los Angeles and therefore receives many charity and Medi-Cal referrals at its Burbank branch. Sun Plus refers these to the private foundation which remains in place of the VNA.

- *Medi-Cal Program Issues*:

    - Sun Plus indicated problems with the TAR process. These include criticism of the Los Angeles office regarding the explanatory second page of the form and that the appeals process is too lengthy.

    - Sun Plus believes there are inconsistencies among the field offices in how policies are applied. In particular, Sun Plus believes each Medi-Cal field office communicates different reporting requirements to the branch offices.

- *Cost Structure*: 30 to 33 percent of Sun Plus costs represent overhead and administration.

UCSD Home Care (UCSD)

UCSD recently underwent a reorganization, resulting in a reduction of 20 FTEs and $1.8 million in expenses. UCSD Home Care is one of the more technologically advanced agencies. For example, some of its nurses are using laptops. This agency receives about 70 percent of its referrals from the UCSD hospital, which used to be the county hospital facility.

- *Impact of Balanced Budget Act*: UCSD estimates that given the BBA Medicare cost limits, the agency will lose about $500,000 overall in their next fiscal year (July 1, 1998 - June 30, 1999).

- *Surety Bond Impact*: UCSD Home Care does not foresee a problem obtaining bonds.

- *Participation in Managed Care Contracts*: UCSD's hospital is applying for Medi-Cal managed care provider status, and may be able to take default patients as early as next year. Currently UCSD serves fewer than 100,000 lives under capitated managed care contracts.

- *Access Issues*: The UCSD hospital system is committed to providing a continuum of care and does not limit the number of Medi-Cal patients it serves. However, this agency described ongoing problems with its field office, related to the TAR approval process.

- *Medi-Cal Program Issues*:

    - UCSD believes the Medi-Cal field office denies TARs for no reason. UCSD called these denials "nonsensical" and "denials on a whim." UCSD felt that the field office does not have specific guidance or direction from the State related to approval and denial consistency.

    - UCSD believes the field office personnel are difficult to work with. "They make it difficult to serve the patient." Also, UCSD believes that its field office "operates outside the standard for the rest of the State."

    - UCSD feels there is a general disconnect between legislative mandates, DHS policy, and field office implementation.

- *Cost Structure:* UCSD estimated that roughly 25 percent of its expenses are overhead and administrative.

UCSF Mt. Zion Home Care (UCSF Mt Zion)

This hospital-based agency is in the process of undergoing a merger with Stanford. The merger of its parent hospital and Stanford occurred in November 1997, although the home health agencies have not yet combined their operations. This merger will result in an agency twice the size of UCSF. Because of the merger with Stanford, the agency has a number of new administrative personnel including its director. The agency primarily receives referrals from its two affiliated hospitals, as well as clinics, doctors and various community resources. This agency was the most urban organization visited, with approximately 83 percent of the population served residing in the City of San Francisco.

- *Impact of Balanced Budget Act*: Based on its fiscal year, UCSF Mt. Zion will not receive Medicare reimbursement under the Interim Payment System until September 1998. Currently, its average Medicare costs are under the per visit limits in all areas except for home health aides. It has hired a consultant to look at the impact of the Interim Payment System on its reimbursement, but this analysis has not been completed.

- *Surety Bond Impact*: UCSF Mt. Zion is not concerned about this requirement, due to their hospital affiliation.

- *Participation in Managed Care Contracts*: The agency serves a number of capitated and other managed care contracts. It has not found managed care to be financially advantageous. The hospitals make the decisions about whether or not to participate in the managed care contracts.

- *Medi-Cal Program Issues*: UCSF did not have many process-related complaints about the Medi-Cal program. However, this agency specifically complained about the rates, and expressed frustration that the field office would not provide them with example TARs or related instructions. However, agency personnel stated that they do not have a problem with TAR denials, and that any denials have been found to be due to internal errors on their part.

- *Access Issues*: UCSF Mt. Zion operates in San Francisco county. Agency representatives believe that they have 15 percent market share and that most of the Medi-Cal beneficiaries are referred to their agency. The agency does not limit the number of Medi-Cal referrals it accepts, nor does it have any plans to.

- *Cost Structure*: This agency had approximately 65 percent direct versus 35 percent indirect costs. In their opinion, this represents a good cost structure for a large metropolitan teaching facility.

VNA of the Inland Counties (VNA)

The VNA of the Inland Counties serves a primarily rural population in Riverside and San Bernardino Counties. This agency has a number of branches throughout these counties. The majority of their referrals come from physicians, because many of the hospitals in their service area have their own home health agencies. Agency officials see its freestanding status as an advantage because it enables them to take referrals from all sources.

- *Impact of Balanced Budget Act*: The Interim Payment System has impacted the VNA by reducing its Medicare reimbursement to just under costs. Due to recent reductions in visit volume and the changes in the per visit limits, the VNA is right at its per visit limits. The agency estimates that its per beneficiary limit will be approximately $3,500, but believes there is a chance the lower limits will not have much impact. The VNA is also looking carefully at Medicare utilization, and is concerned that decreasing utilization could have a negative impact. Agency officials stated that if Medicare reimbursement drops further, they may have to further restrict Medi-Cal.

- *Surety Bond Impact*: The VNA solicited bonds from 16 sources and found two sources willing to issue the necessary Medicare bonds; however, the agency is holding off on obtaining the bonds until required.

- *Participation in Managed Care Contracts*: The VNA of the Inland Counties is participating in approximately 120 managed care contracts, of which 10 to 15 make up the majority of the volume. The agency estimates that just over 50 percent of senior citizens in its service areas are enrolled in Medicare managed care. The VNA has found that it serves more managed care in its rural areas and less managed care through its Riverside branch.

- *Medi-Cal Program Issues*: The VNA feels it has a good relationship with its field office. The agency rarely works with the straight TAR process. Most often its Medi-Cal patients come through the case managers at the hospitals and TARs are pre-approved. The agency has had some denials which resulted in writeoffs; in 1996 these amounted to $70,000, although it is expected to be lower in 1997.

- *Access Issues*: The VNA does limit its acceptance of Medi-Cal referrals. This agency will only take Medi-Cal referrals from certain sources. Overall, the agency guideline restricts Medi-Cal referrals to three percent of total referrals. In addition, the VNA will not take any Medi-Cal referrals from hospitals that have their own home health agency.

- *Cost Structure*: Based on FTEs, the VNA's indirect costs are approximately 33 percent.

Summary

The site visits revealed several important issues facing home health agencies in California, including financial concerns caused by Medicare reimbursement changes and difficulties with the Medi-Cal TAR process and field offices. First, the agencies we spoke with felt that the TAR process was difficult and inconsistent. Agencies believed that both the Discharge Planning Option and the Medical Case Management programs were working well. In particular, several agency officials opined that the latter program should be expanded or used as a model for all fee-for-service authorizations. For some providers, the difficulties they have experienced in obtaining approval of TARs affect their willingness to provide services to Medi-Cal beneficiaries.

Since Medicare represents the largest single payor for all of the providers we interviewed, the reduction in revenues as a result of the BBA is a major concern that could affect their ability to survive. One provider has experienced a decrease in Medicare utilization, which is one indicator that home health services are becoming less accessible to Medicare beneficiaries. This provider did not indicate a corresponding drop in Medi-Cal utilization but acknowledged that further reductions in Medicare revenues may ultimately affect its ability to serve Medi-Cal beneficiaries.

Finally, with the increased trend toward cost control through managed care, two providers stated that they have rejected managed care contracts that would have reimbursed them at rates lower than Medi-Cal rates. Both of these providers continue to serve Medi-Cal fee-for-service beneficiaries.

In summary, we found that Medicare issues dominated the topics discussed by home health agencies during these site visits. While some providers had specific complaints regarding Medi-Cal field office communications or operations, none of the interviews indicated any future threat to Medi-Cal access.

6. ACCESS TO HOME HEALTH CARE FOR MEDI-CAL RECIPIENTS

To determine whether there is adequate access to home health services by Medi-Cal recipients, we analyzed various access indicators. These included the trend in Medi-Cal home health expenditures and users as well as the number of providers serving Medi-Cal beneficiaries in each county. Where appropriate, these trends were compared to those of the general population, particularly to Medicare, although it is difficult to quantify home health access across various user groups. Most sources of data contain information from agencies that serve only Medicare and/or Medi-Cal beneficiaries. Data regarding other users are generally projected from the 1987 National Medical Expenditure Survey and may be incomplete, especially for State estimates. In addition, the demographics of the Medi-Cal population differ from that of Medicare and the general population. In this Chapter, we also analyzed the outcomes of Treatment Authorization Requests in response to some of the provider concerns regarding their willingness to serve Medi-Cal beneficiaries identified in the site visits.

Statewide Trends in Home Health Agency Statistics

In 1997, the State of California spent over $60 million for Medi-Cal home health services. Home health expenditures and the number of users as a percentage of total Medi-Cal eligibles have increased steadily over the past five years, as illustrated in the table below.[33]

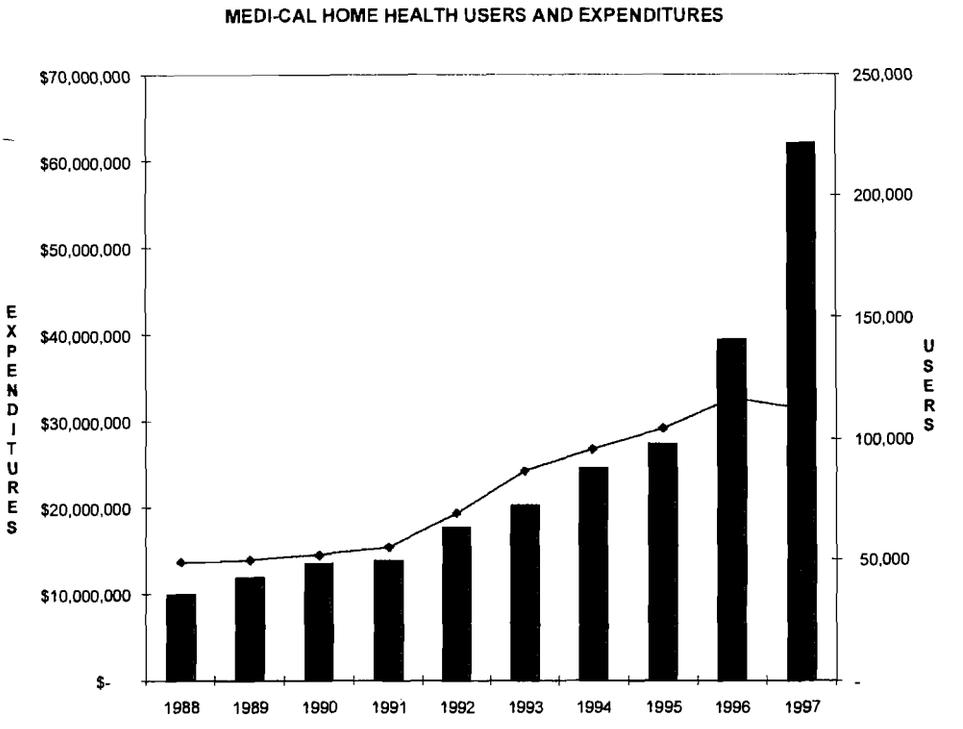
Calendar Year	Medi-Cal Eligibles	Medi-Cal Home Health		
		Expenditures	Users	% of Medi-Cal Users
1992	4,383,978	$17,559,354	5,752	0.13%
1993	4,720,244	20,201,248	7,216	0.15%
1994	4,903,150	24,588,458	7,967	0.16%
1995	4,720,764	27,307,130	8,682	0.18%
1996	4,380,337	39,340,027	9,726	0.22%
1997	3,653,955	61,922,359	9,363	0.26%

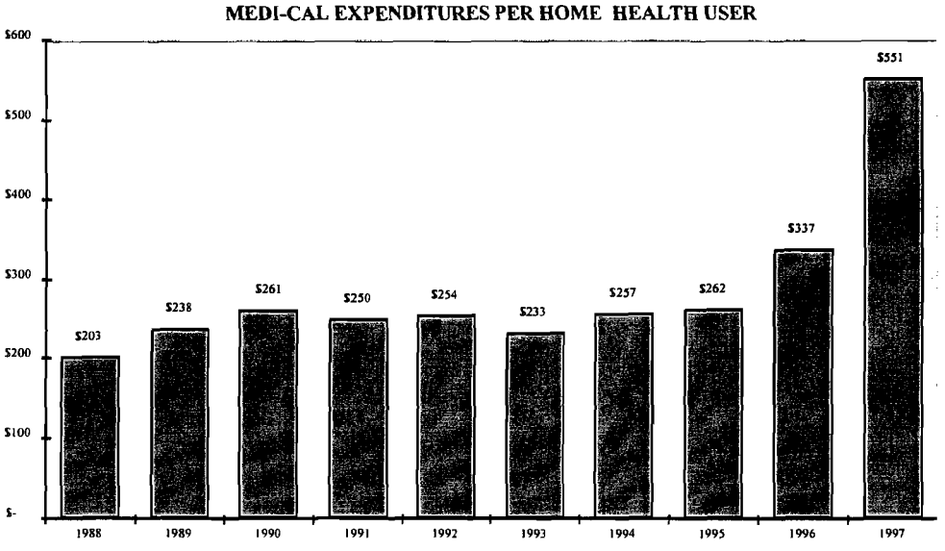
253%↑

Source: Medi-Cal Services and Expenditures Month-of-Payment Reports for Calendar Years 1992-1997.

The table indicates that expenditures more than doubled between 1995 to 1997, which is likely due to the authorization of 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. Between 1992 and 1997, Medi-Cal expenditures more than tripled. In comparison, national Medicare home health expenditures more than doubled from $7.9 billion in 1995 to $20.5 billion in 1997.[34] The charts below illustrate the trends in annual Medi-Cal home health expenditures and users for the period from 1988 to 1997.

[33] Eligibles and Users represent monthly averages; Expenditures represent annual amounts paid.
[34] Basic Statistics About Home Care 1997, Table 8, The National Association for Home Care Web Page.





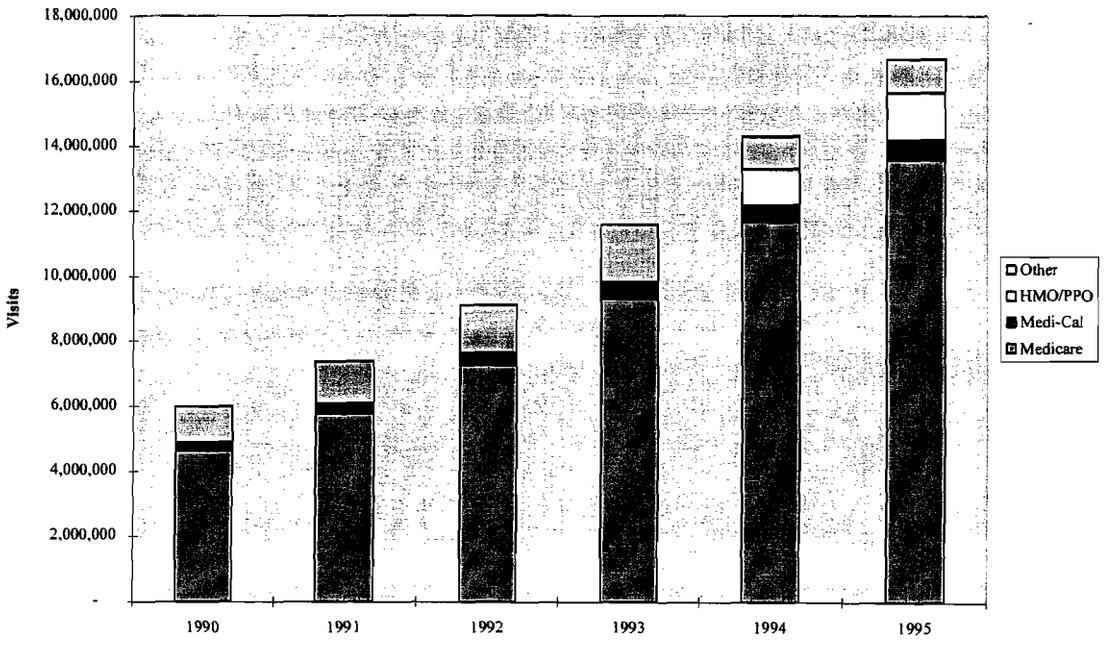
Source: Medi-Cal Services and Expenditures Month-of-Payment Reports for Calendar Years 1988-1997.

To determine the number of providers serving Medi-Cal beneficiaries, we utilized data from the Annual Reports of Home Health Agencies in the State of California. This data is maintained by the State's Office of Statewide Health Planning and Development (OSHPD) and is one of the most comprehensive sources for specific information regarding home health agencies.

Unfortunately, 1995 represents the most recent data. Given the transition which the industry has seen in the past three years, this data may not accurately represent the current status of the home health industry in California. In addition, as the OSHPD database is based on submittals by licensed agencies, it may not be complete. Our analysis of OSHPD data focused on a subset dataset that included only home health agencies designating a valid agency type (i.e., for-profit, not-for-profit).

The 1995 OSHPD data included 1,247 home health agencies. Of these, 131 agencies did not designate a valid agency type and were excluded, resulting in 1,116 agencies in our analysis. 83 percent of these agencies were certified to provide Medi-Cal services. In addition, 68 percent were for-profit, 28 percent were private not-for-profit facilities and 4 percent were government not-for-profit facilities. The total number of visits reported for home health agencies included in 1995 OSHPD data was 16.7 million, up from 6.0 million in 1990. The growth in home health visits is shown in the graph below.

Home Health Visits in California in 1995



Source: Annual Reports of Home Health Agencies, Office of Statewide Health Planning and Development.

In 1995, 81 percent of visits were Medicare, 4 percent were Medi-Cal, 9 percent were HMO/PPO and 6 percent were Other visits. The number of visits more than doubled for Medi-Cal, Medicare and total visits from 1990 to 1995. Of the 15 agencies with the highest percentages of Medi-Cal visits, 11 were not-for-profit government, 2 were not-for-profit private and 2 were for-profit agencies. Over half of the Medi-Cal visits were provided by 51 of the facilities analyzed. Of these 51 facilities, the majority (76 percent or 39 facilities) were not-for-profit private facilities. According to Licensing and Certification, the total number of licensed agencies in the State of California as of January 20, 1998 was 1,337.[35] This includes all licensed sub-units and branches required to be licensed separately in California.

In 1995, 64 percent (712) of the agencies in the OSHPD database provided home health services to Medi-Cal beneficiaries. Based on our site visits, we found that non-profit agencies generally accept all Medi-Cal referrals (the only exception was the VNA of the Inland Counties that limited the number of referrals they will accept). In order to determine whether Medi-Cal beneficiaries were receiving home health services to the extent these services were generally available throughout the State, we analyzed agencies on a county by county basis. Specifically, we determined the number of counties that had at least one Medi-Cal facility (defined as reporting at least 60 annual Medi-Cal visits in the respective year in the OSHPD database).

In 1990, 431 home health agencies in 51 counties submitted Annual Reports with valid agency types to OSHPD. Of these, 49 counties had at least one Medi-Cal facility. In the 1995 OSHPD database, 53 out of 54 counties had at least one Medi-Cal facility. In addition, the number of Medi-Cal facilities more than doubled from 277 to 522 between 1990 and 1995. Of the 54 counties in California, 39 experienced growth in the number of Medi-Cal facilities, and 48 counties experienced growth in the number of Medi-Cal visits over this period. In most of these counties, the increase in both of these factors was more than 50%. For example, in San Joaquin, County, the number of Medi-Cal facilities grew from 3 to 8, while the number of visits increased from 2,193 to 11,354 from 1990 to 1995. The growth rates in the number of facilities and visits for Medi-Cal parallel the corresponding trends in Medicare, although the Medicare growth rates were generally greater.

All counties reporting home health agency data except San Benito had one or more Medi-Cal facilities in 1995. San Benito County had one home health agency listed in the OSHPD database; this Medi-Cal certified agency provided about 18,500 visits in 1995, none of which were Medi-Cal visits. Because of San Benito County's relatively small geographic area and its proximity to the Bay area and Fresno, it appears that Medi-Cal beneficiaries in this county requiring home health services receive services from agencies in surrounding counties.

This analysis also assumes that home health agencies generally provide services throughout the county where they are located. In our discussions with agencies, we found this to be the case; in

[35] Phone interview with Jennifer Sugar, based on data from the ACLAIMS database.

fact, many agencies covered not only the county in which they were located, but a larger geographic area.

Analysis of Treatment Authorization Request Outcomes

In our site visits, several agencies mentioned concerns regarding discrepancies between Medi-Cal policies and implementation of these policies by the field offices. Discussions with DHS personnel indicated that although some level of inconsistency is inherent in the system, given that there are seven field offices, the State provides standard guidelines and clarification of policy to each field office. The "Manual of Criteria for Medi-Cal Authorization" is used to determine if a TAR is appropriate, and Field Office Instruction Notices (FINs) are issued by the policy to discuss and clarify relevant topics.

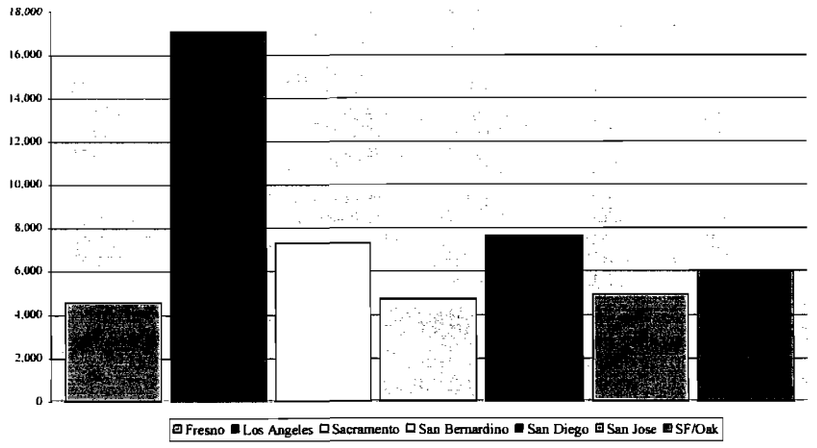
Another concern affecting access to home health agencies by Medi-Cal beneficiaries appeared to be the TAR process. In order to evaluate this process, we obtained monthly data for 1997 from DHS regarding the number of TARs processed that resulted in approval, denial, deferral or modification for each field office. The results are indicated in the table below and the graphs on the following page. In general, this analysis underscores the lengthy timing of the process. Note that in 1997, on average, only eight percent of home health TARs were denied.

Summary of TARs by Field Office for 1997

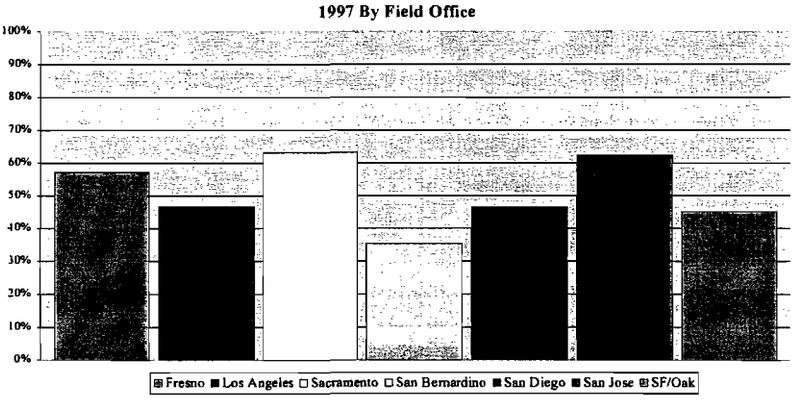
		Percentage				
Field Office	Total Processed	Approved	Modified	Deferred	Denied	Average Processing Time (Days)
Fresno	4,575	57	12	26	4	18.8
Los Angeles	17,060	47	23	19	12	12.4
Sacramento	7,256	63	20	12	4	13.0
San Bernardino	4,700	35	36	17	11	8.8
San Diego	7,582	46	17	29	8	7.5
San Francisco (& Oakland)	5,989	45	28	22	5	11.3
San Jose	4,914	62	10	24	4	13.4
Statewide	52,076	50	21	21	8	12.0

Source: DHS, Medi-Cal Operations Division. Represents monthly TAR outcomes aggregated for 1997 calendar year. Some of the approved, modified and denied TARs may represent recycled TARs that had previously been deferred. Note that the San Francisco and Oakland field offices merged as of October 1, 1997; for this analysis, data for these two offices were combined for the period January to September 1997.

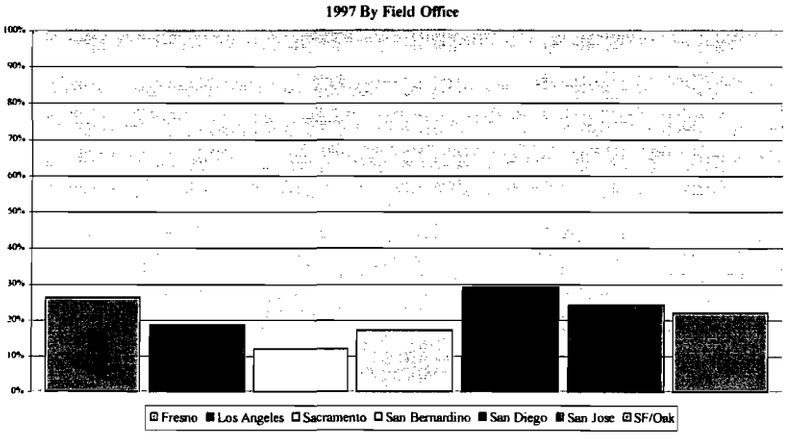
Total TARs Processed
1997 By Field Office



Percentage Approved
1997 By Field Office



Percentage Deferred
1997 By Field Office



Our analysis of the 1997 TAR data indicates the following:

- The Los Angeles office processes a much larger number of home health agency TARs than the other field offices. This office processes over 1,400 TARs monthly on average, while the other six field offices processed on average from 345 to 632 TARs monthly.

- None of the field offices (with the possible exception of the San Bernardino office) appear to be treating TARs significantly differently than the other offices, or as compared to the statewide averages. On average, nearly 50 percent of TARs were approved each month for each of the field offices.

- On average, the turnaround time exceeds the ten day limit for most of the field offices. The Fresno office in particular has the longest average processing time at 18.8 days. Our analysis did not consider potentially significant backlogs in TAR processing at DHS. Timeliness of the TAR process was one of the major problems identified by providers with whom we spoke.

- In examining the TAR outcomes by month, we did not note any seasonal variations, as suggested by providers during our site visits. However, we do note that the TAR data includes "deferred" as an option, and thus there is no way to know how many of the TARs included in the totals have already been submitted and deferred.

Summary

Our examination of available data indicates that there appears to be adequate access to home health services for Medi-Cal beneficiaries as compared to the general population. Medi-Cal home health expenditures have increased from $17.6 million in 1992 to $61.9 million in 1997. The increases in expenditures, users as a percentage of eligibles and expenditures per user indicate an expansion of services over the last five years that corresponds to the trend in Medicare home health expenditures. In addition, the State experienced significant growth in the number of home health agencies and number of visits serving Medi-Cal and other beneficiaries between 1990 and 1995. Our analysis indicated that every county except one that reported home health visits in 1995 had one or more agencies providing 60 or more Medi-Cal visits.

Our analysis of TAR processing time indicated that the average turnaround time of 12 days exceeded the ten-day limit for most offices. During our site visits, providers discussed their concerns relating to TAR processing time and consistency in implementing State home health policies. Although these concerns may impact providers' decisions about whether or not to serve Medi-Cal beneficiaries, they do not appear to have significantly affected access to home health services based upon our analysis.

7. SUMMARY OF FINDINGS

The purpose of this report is to evaluate and compare the access to home health services by Medi-Cal beneficiaries and the general population in the State of California. This work was completed through an examination of the home health industry, site visits to selected home health agencies and an analysis of access indicators. Our review indicates that there is currently adequate access to home health services for Medi-Cal beneficiaries throughout the State of California. This conclusion is based upon the following:

- Increases in expenditures, users as a percentage of eligibles and expenditures per user over the last five years indicate an expansion of Medi-Cal home health services that parallel the trends in Medicare home health expenditures.

- Increases in the number of home health agencies and number of visits serving Medi-Cal beneficiaries between 1990 and 1995 also correspond to visit and agency trends related to Medicare. Our analysis indicated that every county except one that reported home health visits in 1995 had one or more agencies providing at least 60 annual Medi-Cal visits.

- The six sites that we visited provided services to Medi-Cal beneficiaries, although two providers indicated that they limit the number of visits. Historically, Medi-Cal rates have been lower than Medicare rates, but the gap is narrowing due to the provisions of the Balanced Budget Act of 1997. In addition, some providers have been offered managed care contracts with rates that are lower than Medi-Cal's. Home health agencies are struggling to adapt to the lower rates and increased administrative requirements that the industry is now facing.

- Although the providers from our site visits expressed concerns about implementation of Medi-Cal home health policies and the timeliness of the TAR approval process, these concerns do not appear to have had significant impact on the access of Medi-Cal beneficiaries to home health services in the State.

In addition to the above, our study indicated that recent legislative and regulatory changes in the Medicare program may result in decreased access by Medicare beneficiaries, at least for the short-term, due to the provisions of the Balanced Budget Act of 1997. From our examination of the home health industry and our site visits, it is apparent that the industry is undergoing significant changes in responding to the new provisions. Since Medicare is the primary payor of home health services, it is expected that most providers will be forced to cut costs and become more efficient as they struggle to meet the new administrative requirements with decreased revenues. Although it is too early to quantify the effect on Medi-Cal beneficiaries from these changes, our site visit discussions did not indicate an adverse effect at this time. However, over the long term, providers that do not adapt their operations to the efficiencies required by the Medicare program may not survive. The National Association of Home Care noted that due to

Medicare reimbursement reductions caused by the Balanced Budget Act, "reductions in home health utilization [in 1998] could result in agency closures and a loss of access to home health services for some beneficiaries."[36] Such closures may impact access to home health services for all users, including Medi-Cal beneficiaries, in the State of California.

[36] Basic Statistics About Home Care 1997, Page 7, The National Association for Home Care Web Page.