FOLEY

FOLEY & LARDNER LLP

ATTORNEYS AT LAW

555 SOUTH FLOWER STREET, SUITE 3500
LOS ANGELES, CA 90071-2411
213.972.4500 TEL
213.486.0065 FAX
foley.com

WRITER'S DIRECT LINE
213.972.4682
jbates@foley.com EMAIL

August 8, 2008

CLIENT/MATTER NUMBER
112295-0909

**VIA HAND DELIVERY**

Marie Taketa
Chief, Rate Analysis Unit
Rate Development Branch
Department of Health Care Services
1501 Capitol Avenue, MS 4612
Sacramento, CA 95814-7413

Re: Medi-Cal Home Health Rate Review With Consideration of Efficiency, Economy, Quality of Care, And Access

Dear Ms. Taketa:

In accordance with the Notice of General Public Interest published in the California Regulatory Notice Register on June 27, 2008, we are submitting written comments on the referenced reimbursement rate review report. The following comments are submitted with this letter:

- Comments submitted on behalf of California Association for Health Services at Home by Robert C. Leventhal of Foley & Lardner LLP; and
- Report submitted on behalf of California Association for Health Services at Home by Henry W. Zaretsky, Ph.D.

If you have any questions regarding these submissions, please let me know.

Very truly yours,

Jeffrey R. Bates

Enclosures

cc: Joseph Hafkenschiel
Robert C. Leventhal
Henry W. Zaretsky, Ph.D.

# DEPARTMENT OF HEALTH CARE SERVICES

# MEDI-CAL HOME HEALTH RATE HEARING

# COMMENTS OF CALIFORNIA ASSOCIATION FOR HEALTH SERVICES AT HOME

## AUGUST 8, 2008

Submitted By:

ROBERT C. LEVENTHAL
FOLEY & LARDNER LLP
555 South Flower Street, Suite 3500
Los Angeles, California 90071
213-972-4500
213-486-0065 (fax)

Attorneys for California Association
for Health Services at Home

## TABLE OF CONTENTS

## EXHIBITS

A. Declaration of Gina Henning, dated February 15, 2005, filed in *California Nurses Association v. Schwarzenegger*, Case No. 04CS01725 (Superior Court for the County of Sacramento)

B. California Nurse Education Initiative, Annual Report 2007

C. Final Statement of Reasons of Department of Health Services in Rulemaking Procedure R-37-01, August 25, 2003

D. Transcript of Testimony before the California State Assembly, Budget Subcommittee #1, Health and Human Services, November 16, 2005

E. *Alaska Department of Health and Social Services v. Centers for Medicare and Medicaid Services*, 424 F.3d 931 (9th Cir. 2005)

F. Brief of Respondents Centers for Medicare and Medicaid Services in *Alaska Department of Health and Social Services v. Centers for Medicare and Medicaid Services*, 424 F.3d 931 (9th Cir. 2005)

G. Oregon Medicaid Home Health Rates effective June 19, 2004; Oregon Medicaid Home Health Rates effective January 1, 2008

## I. INTRODUCTION

The Department of Health Care Services was ordered to perform annual rate reviews covering the Medi-Cal reimbursement rates paid to the providers of home health care services for the years 2001 through 2005. *California Association for Health Services at Home v. Department of Health Services*, 148 Cal. App. 4th 696 (2007); Superior Court Writ of Mandate dated April 8, 2008. The purported rate review issued by the Department fails to comply with the requirements of the Court Orders, California law, the State Medicaid Plan, and federal Medicaid law.

The applicable law, and the Court Orders, required the Department to conduct an annual rate study to ensure that the Medi-Cal rates paid to providers of home health care services are "**consistent with** efficiency, economy, and quality of care" and "**sufficient to** enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area." The Department's purported rate study neither analyzes the adequacy of the Medi-Cal rates nor examines whether those rates were sufficient to enlist enough providers so that home health care and services are available to Medi-Cal beneficiaries at least to the same extent that the services are available to the general population. Instead of performing a meaningful rate study as required by the Court, the Department has simply cited to irrelevant data (including data from the **wrong decade**) and, without conducting any valid analysis of this irrelevant data, purported to conclude that the Medi-Cal home health agency rates paid for years 2001 through 2005 were adequate.

Had the Department performed a meaningful rate review using relevant data, it would have undoubtedly discovered that the existing Medi-Cal rates are woefully inadequate and fail to satisfy the statutory mandates. Since the last rate increase in 2000, numerous costs incurred by home health providers have substantially increased. Nurses' wages have risen sharply, due not only to inflation but also to a severe nurse shortage. Likewise, the costs of gasoline, utilities and insurance have also risen.

Had the Department surveyed Medi-Cal patients in need of home health services or hospital discharge planners, it would have learned that it has become increasingly difficult for Medi-Cal beneficiaries to obtain needed home health services. Instead of addressing the serious issues it was ordered to address, the Department looked at irrelevant data that demonstrates nothing, failed to ask the correct questions, and obstinately insisted that there is nothing wrong with the existing rates.

The California Association for Health Services at Home (CAHSAH) itself has not performed a rate study. As the Department has repeatedly pointed out, it is the Department, not health care providers, that has the responsibility for performing rate studies. CAHSAH has neither the responsibility nor the resources to take on the Department's obligations. The Department is required to do a meaningful rate review and, for the reasons pointed out in this Statement of Position and the Report of health care economist Henry Zaretsky ("Zaretsky Report"), it has failed to do so.

The Department should acknowledge that its purported rate study is fatally flawed and should perform a meaningful analysis of the Medi-Cal home health rates and set new, adequate, rates for the years 2001 through the present.[1]

## II. BACKGROUND

Home health care services are an important part of the health care system. The availability of home health services enables hospitals and nursing facilities to discharge patients earlier than they otherwise would. It is better for patients, enabling them to live in the comfort of their own homes. It enables seriously disabled individuals to avoid being institutionalized and allows them to live more productive and independent lives. It is good for the Medi-Cal budget because it is more cost effective than the available

---

[1] Although the Court Orders only required the Department to perform an annual rate review for the years 2001 through 2005, the Department has a statutory and regulatory obligation under both state and federal law to ensure that the existing rates are adequate. When the Department redoes its study, it should not limit itself to examining the rates up to 2005, but should also determine what the current rates should be.

alternatives – care in a hospital or other institution. Anything that decreases the availability of home health services to Medi-Cal patients will not only reduce the patients' quality of care and quality of life, it will also **increase** the overall costs incurred by the Medi-Cal program. Inadequate reimbursement of home health providers will adversely impact the availability of such care and will needlessly increase Medi-Cal expenditures.

The Department has not increased the rates paid to home health providers since August 2000. Its failure to raise rates defies logic. Since August of 2000 the costs incurred by health care providers have significantly increased. The cost increases faced by home health agencies have been particularly severe.

One of the main costs that home health agencies must incur is the cost of employing registered nurses and licensed vocational nurses. California has been experiencing a severe nurse shortage. As Department employee Gina Henning acknowledged under oath:

> The nursing shortage in California is severe. California consistently ranks 49th or 50th among the states in the number of nurses per capita. In addition, the nurses in California are aging, with the average age being 49. California only trains about half the nurses needed and relies on nurses coming from other states and countries. California's population is also growing every year and aging, increasing the demand for health care.

(Declaration of Gina Henning at ¶ 22 (Exhibit A hereto).) Likewise, Governor Schwarzenegger's administration has acknowledged that there is "a critical shortage of Registered Nurses (RNs) in California. [In 2005], California faced a shortage of 9,900 RNs annually, with this number slated to accumulate to 47,600 RNs by 2010 and 116,600 by 2020." (California Nurse Education Initiative, Annual Report 2007, at p. 3 (Exhibit B hereto).)

The nurse shortage has increased the competition for, and cost of hiring, nurses. The Department recognized as much when it referred to "the high (and steadily increasing) cost of replacing nursing staff" in its Final Statement of Reasons in support of its hospital nurse staffing ratio regulations. (*See* Final Statement of Reasons of Department of Health Services regarding Rulemaking Proceeding R-37-01 at p. 6 (Exhibit C hereto).) Further, the economic impact of the nurse shortage has been exacerbated by California's implementation of hospital nurse staffing ratios that became effective on January 1, 2004. These staffing ratios significantly increased the number of registered nurses and licensed vocational nurses that hospitals had to hire and, because of the nursing shortage, significantly increased the costs of hiring and retaining nurses for all California health care providers. The impact of the nurse staffing ratios began well before their implementation in January 2004 as hospitals increased their staffing in anticipation of the required ratios.

Additionally, because of the increased staffing levels, hospitals became a more attractive career option for nurses. The Department recognized as much when it cited a "study [that] showed that nurses who worked in hospitals with the highest nurse-to-patient ratios were more than twice as likely as nurses who worked at lower ratios to report burnout and job dissatisfaction, and four times as likely to report that they intended to leave their current jobs within one year. " The Department specifically found that the new nurse staffing ratios "may . . . improve staff retention." (Final Statement of Reasons at p. 5-6 (Exhibit C hereto).) The increased attractiveness of hospital employment placed greater pressure on home health agencies, making it harder and more expensive to retain and recruit high quality nurses.

Prevailing wage data from the Bureau of Labor Statistics confirms the obvious: nursing wages have substantially increased from 2000 to the present. The mean hourly wage for a registered nurse increased 25.5 % between 2000 and the end of 2005. Between 2000 and the end of 2007 it increased 40%. Likewise, the mean hourly wage

for an LVN increased 18.3 % between 2000 and 2005, and 29% between 2000 and 2007. (*See* Zaretsky Report at p. 7, Table 6.) Likewise the costs of overhead, workers' compensation insurance, gas, and other costs incurred by home health providers increased significantly between 2000, 2005 and 2007. (*Id.* at p. 6, Table 5.) Additionally, other expenses, such as the cost of gasoline, have risen significantly since 2000. Home health providers drive from client to client and the cost of transportation, including gasoline, is a major expense that has risen sharply.

The failure to raise Medi-Cal rates to cover the significant increases in the cost of providing home health services would be expected to result in a reduction in the Medi-Cal beneficiaries' access to home health services. And this expected result is exactly what occurred, according to the Department's own data. For example, in 2001 (the first year of data the Department included in its purported rate study), there were 85 more home health providers that accepted Medicare than accepted Medi-Cal. By 2005, this gap had **more than doubled**, with 188 more home health Medicare providers than home health Medi-Cal providers. (*See* Rate Study at p. 14, Table 7.)

Despite the fact that readily available data, some of which was actually cited by the Department, demonstrate that the costs of providing home health services have significantly risen, on an annual basis, between 2000 and the present, and that access to home health services for Medi-Cal beneficiaries has fallen, the Department simply ignored the evidence and, without any basis in fact or logic, purported to conclude that there is no cost problem and there is no access problem.

The Department's purported rate study fails to comply with the requirements of the State Medicaid Plan, California law, federal Medicaid law, the California Court of Appeal's decision in *California Association for Health Services at Home v. Department of Health Services*, 148 Cal. App. 4th 696 (2007), or the Superior Court's writ of mandate. To call the rate study "arbitrary and capricious" would be charitable. The Department's willful refusal to obey the Courts' Orders is demonstrated by the fact that

the only actual study on which the Department relies is a study performed by Tucker Alan, Inc., in **1998** which looked at the years **1988 through 1997**. The Department is relying on data **from the wrong decade.**

The Department is well aware of the increased costs faced by home health providers and the need for a Medi-Cal rate increase. It raised the rates for skilled nursing facilities three times between 2000 and 2005, and in 2005 began a new reimbursement system under which it reimburses skilled nursing facilities for the full costs (subject to certain limits) that they incur in providing Medi-Cal services. Since the major variable cost incurred by home health agencies and skilled nursing facilities is the same – the cost of employing nursing staff – there is no rational basis for raising the rates for skilled nursing facilities but not for home health agencies. This is particularly true because it costs less to provide home health services to patients than to place them in a facility. Home health care is both more pleasant for the patient, who gets to live at home, and more economical for the State. (*See* Testimony of Sharon Turner before the California State Assembly Budget Subcommittee #1 (Exhibit D hereto).)

The California Association for Health Services at Home and its members respectfully request that the Department start from square one and do an unbiased, meaningful analysis of the costs of providing home health care services on an annual basis from 2000 through the present. Based on this analysis, the Department should set rates for each annual period that are consistent with efficiency, economy, and quality of care, are reasonably related to the costs incurred by an efficient and economical home health provider in providing services to Medi-Cal beneficiaries, and which are sufficient to ensure that Medi-Cal beneficiaries have access to home health care services similar to that available to the general population in the geographic area. This is what the Court ordered. This is what the law requires. This is what must be done.

## III. ANALYSIS

### A. The Department's Discussion Of The "Efficiency And Economy" Provision Is Both Erroneous And Irrelevant.

The Department acknowledges that the Ninth Circuit Court of Appeals held in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (1997), that the Department must set rates that "bear a reasonable relationship to an efficient and economical [provider]'s costs in providing quality care." (Rate Study at p. 5, *Orthopaedic* at 1500), and that "the Department must rely on responsible cost studies, its own or others, that provide reliable data as a basis for its rate setting." (*Id., Orthopaedic* at 1496.) However, the Department does not even pretend that it relied on responsible cost studies, or even that it considered the costs of economic and efficient home health providers as part of the Rate Study. Instead, the Department erroneously claims that the cost study requirement of *Orthopaedic* is no longer good law.

The Department's legal argument is erroneous. The two cases that the Department cites for the proposition that the *Orthopaedic* standard is no longer applicable did not decide that issue. Rather, they simply addressed whether recipients and providers have a private right of action under a federal statute, 42 U.S.C. § 1983, to enforce certain sections of the Medicaid Act. The court concluded that "Congress did not unambiguously create an individually enforceable right in [42 U.S.C. § 1396a(a)(30)(A)] that would be remediable under § 1983 by either recipients or providers of medical services." *Sanchez v. Johnson*, 416 F. 3d 1051, 1068 (9th Cir. 2005). *See also Ball v. Rodgers*, 492 F.3d 1094, 1097 (9th Cir. 2007) (citing *Sanchez* for the proposition that § 30(A) is not enforceable under § 1983). However, neither case held that the *Orthopaedic* requirement that rates be reasonably related to the costs of an efficient and economical provider was no longer in effect.

In fact, the Ninth Circuit reiterated the validity of the *Orthopaedic* standard in *Alaska Department of Health and Social Services v. Centers for Medicare and Medicaid*

*Services*, 424 F.3d 931, 940 (9th Cir. 2005) (Exhibit E hereto), a case that was decided after *Sanchez.* In that case, the Ninth Circuit specifically relied on *Orthopaedic Hospital* and stated as follows:

> Specifically, we find no merit in the State's claim that there is no basis for cost-based review of state rate setting. To the contrary, our precedent plainly requires a state to set reimbursement rates "**that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the [state] shows some justification for rates that substantially deviate from such costs.** "

The Ninth Circuit further stated: "The State questions the continuing vitality of our opinion in *Orthopaedic Hospital*, suggesting that subsequent amendments to the Medicaid Act - specifically the repeal of the Boren Amendment – have rendered it inapplicable. **We are not persuaded.**" *Id.* (emphasis added). Thus, the Department's assertion that *Orthopaedic* has somehow been overruled is unsupportable.

The plain meaning of the statutory language "assure that payments are consistent with efficiency, economy, and quality of care" requires that costs be considered when setting rates. The Department's contention that "the 'efficiency and economy' language of the EEQ provision is that 'efficiency and economy' are an upper payment limit" (Rate Review at p. 7) is not only inconsistent with *Orthopaedic* and *Alaska*, it is inconsistent with the plain language of the statute and would lead to absurd results. If the language is merely an upper payment limit, then the Department could set the rates at zero without violating the statutory language. Yet it would be absurd to claim that a payment of zero is "consistent with efficiency and economy." Paying nothing for costly services would not be consistent with efficiency and economy, it would simply be an abdication of the Department's duty to pay for services rendered under the Medi-Cal program.

The plain meaning of the requirement that payments be "consistent with efficiency and economy" is that it sets both an upper payment limit and a floor. Payments cannot be so high that the State is wasting money and encouraging or paying

for inefficiencies. Neither can they be so low that an efficient and economical provider will lose money by providing services to Medicaid beneficiaries. The rates must fall within the range of what economical and efficient providers need to receive to cover the costs associated with providing the services. In its brief filed in the *Alaska* case, the Centers for Medicare and Medicaid Services agrees that the "efficiency and economy" language requires a finding that the "rates are **neither** too high **nor too low**." (Brief For Respondents at p. 36 (emphasis added) (Exhibit F hereto).)

Further, the Department appears to be attempting to obfuscate the meaning of the statute by discussing the "efficiency and economy" language separately from the "quality of care" language. The two requirements are indivisible. The statute requires the Department to "assure that payments are consistent with efficiency, economy, **and quality of care**." This language, taken as a whole, demonstrates that it is not intended to be solely an upper limit on payments. The payments must be low enough not to be wasteful, but high enough to be consistent with quality of care. A payment that is too low to cover the costs of quality care is clearly not consistent with quality care as set forth in the statute. The Department's conclusion "that the rates for Home Health Services for years 2001 through 2005 do not violate any upper limit imposed by 'efficiency' or 'economy'" answers only half the question. The Department has failed to address whether the rates are too low to be consistent with those requirements.

Had the Department considered the correct question, it would have inevitably concluded that the rates are woefully inadequate. For example, if one compares the 2005 Medi-Cal home health rates with the cost of providing services, they are unquestionably too low. The rates are adequate to cover the costs of a skilled nursing visit for only 3.6% of Medi-Cal participating home health agencies. The percentages of agencies whose costs are covered by the Medi-Cal rates for other types of home health visits are: 15.9% for home health aide visits; 1.7% for occupational therapy visits; 0.5% for physical therapy visits; 1.6% for medical social services; and 3.7% for speech therapy. (*See*

Zaretsky Report at p. 5, Table 4.) The rates are clearly not consistent with efficiency, economy or quality of care.

**B. The Department's Quality Of Care Analysis Is Meaningless And Addresses The Wrong Question.**

The Department claims that it looked at quality of care data and has concluded that there is not a quality of care problem for Medi-Cal home health agency services. This conclusion is unsupported by any facts and does not address the quality of care requirements of the statute. The statute requires that the Department "assure that **payments are consistent** with efficiency, economy, and **quality of care**." This language plainly requires the **rates to be consistent** with quality of care. The fact that providers may choose to provide quality services despite inadequate rates does not make the rates consistent with quality of care. For example, if the Department set the rates at zero, there might be some non-profit providers that would provide services of the highest quality free of charge. If the remaining providers ceased providing Medi-Cal services, there would be no evidence of any quality of care problems. Yet the payment of nothing for the services in question would clearly not be consistent with quality of care. The quality of care provision requires the Department to ask whether **the rates are consistent with quality of care** – not whether quality services are still being provided **despite inadequate rates**.

Not only did the Department ask the wrong question when analyzing whether the rates are consistent with quality care, it relied on meaningless data. The sole data sources for the quality of care analysis were the number of complaints about home health agencies received by the Department of Public Health, Licensing and Certification Division for the years 2003 through 2005 and by the California Board of Registered Nursing. The Department did nothing to investigate quality of care, it merely compared the number of complaints received by these two agencies with the total number of home health visits during the years in question and concluded that the complaints "were

statistically insignificant." The Department did not even determine how many of the complaints involved Medi-Cal services. This cursory analysis is on its face insufficient to determine whether quality care is being provided. There is no reason to believe that Medi-Cal recipients are sufficiently knowledgeable about home health services to know when the services that they are receiving are substandard. Nor is there reason to believe that they are sufficiently sophisticated to know which government agency to complain to. The number of complaints does not demonstrate that the rates are consistent with quality care.

Quality care is not just the absence of malpractice. The number of patient complaints to governmental agencies cannot measure it. It is measured by tangible statistics regarding the manner in which the services are rendered – for example, is turnover low enough that there is good continuity of care; and are the caregivers providing services seasoned professionals or are they recent graduates. It takes good wages to attract and keep experienced nurses. Low Medi-Cal rates force providers to pay low wages, which causes high turnover and leads to less experienced caregivers being assigned to Medi-Cal cases. The Department should have looked at these factors, instead of restricting itself to irrelevant data regarding patient complaints to government agencies.

### C. The Department Has Failed To Analyze Whether The Rates "Are 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."

The Department has failed to conduct a meaningful analysis of whether the rates "are 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," as required by the statute. The Department's purported analysis of this issue is a transparent sham. The Department has not even attempted to determine whether Medi-Cal recipients have more difficulty obtaining access to home health services than the general population in their geographic areas. Instead of focusing on the only thing at issue – whether access to home health services is the same for Medi-Cal beneficiaries as it is for others – the Department looks at totally irrelevant data. Incredibly, the Department presents an access study that was performed in 1998 and looks at data from 1988 to 1997 – data from the wrong decade. The Department has been ordered to do a rate study covering the years 2001 through 2005. Providing results from an access study from the wrong decade clearly fails to comply with the Court Orders.

Furthermore, the only study that the Department relies on is not only from the wrong decade, it addresses the wrong issue. According to the Department, its data shows that Medi-Cal beneficiaries' use of home health services grew between 1992 and 1997. However, the issue is not whether the utilization of the services by Medi-Cal beneficiaries grew, the issue is whether Medi-Cal beneficiaries had the same access as the general population. The fact that their use of home health services grew is irrelevant to determining whether their access was comparable to the general population's.

Having looked at the wrong decade, the Department then proceeded to look at the wrong states. Instead of analyzing the adequacy of California's rates, the Department compared California rates to the rates of a few other states – states with very different economies than California.[2] The Department did nothing to determine whether the rates

[2] The Department fails to explain how it selected the states that it used in its comparisons or why it left out other states with higher rates and economies similar to California, such as New York State. The Department also fails to explain how it determined what the rates are in the comparison states, and it appears to have performed questionable calculations in coming up with the purported comparison rates. For example, the Department states that "Washington sets different rates for different geographic areas, The rates above reflect a simple average of the rates at July 1, 2005 reduced by 1%." (Rate Review at p. 14, n. 3.) The Department fails to explain why it used a simple average and why it reduced the average by 1%.

in the other states are adequate to provide equal access to services and neglected to mention that some of those states substantially increased their rates after 2005, the last year for which the Department provided data. For example, Oregon implemented substantial rate increases effective January 1, 2008. The rates for therapy and home health aides approximately doubled, and the rate for skilled nursing visits tripled. (Exhibit G hereto.) Oregon apparently believed that its prior rates (the ones relied on by the Department) were woefully inadequate. The Department also did nothing to adjust the rates from other states to reflect the higher salaries that California employers pay for nurses or the higher minimum wages, workers compensation costs, overhead and other expenses associated with doing business in California. Likewise, the Department failed to take into account the differences in the services covered by the rates from other states. The Department admits that "it is obvious that many states are including other home health services or are paying for different time intervals." (Rate Review at p. 13.) Given these admitted differences, the rate comparison is meaningless.

Next, the Department compares the number of home health providers who provide services to Medicare patients with the number who provide services to Medi-Cal patients. The Department's data demonstrates that there have always been more Medicare providers. The data also shows that the difference has more than doubled between 2001 and 2005. In 2001 there were only 85 fewer Medi-Cal providers than Medicare providers. By 2005 there were 188 fewer Medi-Cal providers. These numbers would cause any reasonable person to question whether Medi-Cal beneficiaries have as much access as the general population. Incredibly, the Department simply ignores this disturbing development and pretends that the data establish that there is equal access.

Finally, the Department reviewed the number of Treatment Authorization Requests that were submitted and approved without modification or deferral during each of the years between 2001 and 2005. The Department notes "Total HHA TARs and the number of approvals increased slightly while the average processing time decreased."

The Department does not explain, nor can it, how this information is relevant to determining whether Medi-Cal beneficiaries have the same access to home health services as the general population.

In *Ball v. Rodgers*, 492 F.3d 1094 (9th Cir. 2007), the Ninth Circuit Court of Appeals held that Medicaid recipients can bring a lawsuit under 42 U.S.C. § 1983 to enforce the Medicaid Act's "free choice" provision (a provision that is applicable to certain waiver programs, including some programs involving home health services). It quoted with apparent approval the District Court's criticisms of the state's failure to insure adequate access to services:

> For example, the state . . . did not survey beneficiaries to ensure that they were receiving adequate services; did not monitor gaps in services; and did not have a grievance procedure in place so that beneficiaries could report these gaps.

Likewise, in the present case, the Department has done nothing to determine if Medi-Cal beneficiaries have equal access to home health services. It has not sought information from hospital discharge planners, who on a daily basis face the difficult task of attempting to locate home health providers to care for Medi-Cal patients upon their discharge from the hospital. It has not surveyed patients who receive home health services to determine if they have adequate access. It has not analyzed data in its possession to determine if there are services that have been authorized, but not delivered in a timely manner because of access problems. It has not investigated whether hospital stays are routinely extended because there are no home health services available for Medi-Cal recipients. It has not studied skilled nursing facilities to determine if there are patients there who would be at home if home health services were easier to access. Had the Department undertaken these steps, it would have learned that there is not equal access to home health services for Medi-Cal patients.

In 2005, the California Legislature held hearings which addressed access to home health services. During those hearings, there was extensive testimony that Medi-Cal beneficiaries lack adequate access to Medi-Cal services. There was testimony that some Medi-Cal beneficiaries are unable to obtain all of the home health care that has been authorized by the Department:

> It is important to know that she gets 112 hours [of shift nursing care] authorized per week, yet she takes 50 to 80 percent of them because they can't get staff. The nurses are interested, but they don't want to work for the rates that they are paid.

(Exhibit D hereto at p. 23, lines. 20 - 24.)

There also was testimony that hospital discharge planners have difficulty placing Medi-Cal patients with home health agencies:

> I and my staff are keenly aware of the daily routine of discharge planners trying to find a home health agency who can staff Medi-Cal patients at the current rates.
>
> If someone needs homecare and no one would take that patient, we must keep the patient in the hospital. **We probably have ten patients, both newborns on ventilators and acute care adults, in our hospital at any given time that could be managed at a lower level of care but are not, because Medi-Cal reimbursement prohibits the agencies from accepting them.**
>
> Let me explain to you how the discharge process works in a hospital. Once a patient is determined to be ready to be discharged, the physician will request for a case manager to arrange for a home health agency to provide a skilled care or service to the patient at home. This usually will continue with the treatment plan started in the hospital. The case manager will contact the home health agency to refer the patient and request service for whatever treatment the physician has ordered.
>
> The home health agency will decide if they have staff and manage the necessary care. The home health agency will frequently refuse Medi-Cal patients, stating that the current Medi-Cal reimbursement is not sufficient to offset the cost of taking care of this patient.

(Exhibit D hereto at p. 25, line 14 to p. 26, line 15.)

Likewise, there was testimony that many home health providers turn away Medi-Cal patients because they cannot afford to treat them given the inadequacy of the rates:

> In light of the nursing shortage I want to point out we do have a successful recruiting program. We do have many nurses that want to come to us, that want to provide the one-on-one nursing care in the homecare setting. But when they learn about the pay rate that we have to pay based on the Medi-Cal reimbursement, they walk away. And it's very evident.
>
> On an ongoing basis we have families who plead with us to take their cases. And not only current referrals, but then also patients on service, who are afraid that we may discharge them based on our inability to staff them should their nurse leave.
>
> To give you a matter of statistics, in 2003 we turned away 6,800 hours of care. In 2004 we turned away 9,800 hours of care. And so far, over three months we will look at turning away 14,000 hours of care. And this is only one home health agency that services parts of L.A. and Orange County.

(Exhibit D hereto at p. 29, lines 5 – 22.)

Another home health provider testified as follows:

> As we have said, we have not received a rate increase since 2001 -- 2000, and at that time it was the 10 percent. But as you know, not getting -- it is getting more and more difficult. We are in competition with the acute care hospitals and skilled facilities and all other providers for that very scarce commodity called a nurse. And there is a great deal of competition. We are unable to keep up in terms of the salaries that are being provided, which means that that also limits -- because it increases our costs, it limits the access to the number of beneficiaries that we can provide.
>
> Then added, because we, like our colleagues who are delivering equipment and making that -- we're make home visits. So we're looking at also the additional cost of gas,

> which I wish I could -- I'm always amazed to think that I'm thrilled that it's now down to $2.49 a gallon instead of $3.00. But our employees are faced with that. We're looking at having to reimburse for that.
>
> Additionally, our workman's comp insurance is higher than what the average hospital is, and that's because we are exposed. They consider us a high-risk exposure because we are out on the roads.
>
> The current Medi-Cal rate has dramatically reduced my agency's ability to provide the care. And because our -- we deliver care in a rural area, that limits, in turn, the access for the individual, which means that they either have to stay in a higher level of care, in an institution.
>
> And our first obligation is to our local hospital and seeing that those Medi-Cal patients are transferred out. Which means those that are in the Sutters or those that are in the Bay Area, those patients don't get to come home because there is limited access to them.

(Exhibit D hereto at p. 33, line 10 to p. 34, line 20.)

The testimony is consistent with the Department's own data showing the growing gap between the number of providers that accept Medicare but not Medicaid. The testimony is further reinforced by the findings in the Zaretsky Report that in 2005 only 518 home health agencies performed one or more Medi-Cal visits compared to 676 agencies that performed one or more Medicare visits. When one limits the data to agencies that provide a significant number of visits, the difference gets even more significant. There were 664 agencies that performed 60 or more Medicare visits, while only 360 agencies performed 60 or more Medi-Cal visits, a staggering difference of over 300. (Zaretsky Report at p. 2, Table 1.)

Further, the Department has data in its possession that could be used to determine whether Medi-Cal patients have adequate access. It could examine the number of hours of shift nursing that it approved for a given time period and compare the hours approved

with the hours delivered. If the hours approved significantly exceed the hours delivered, the Department would know that there is an access problem.

The Department has totally failed to look at the access issue. Medi-Cal patients are in dire need of essential home health services, but have been prevented from having access to the services because of the inadequate rates that the Medi-Cal program offers to home health providers.

## IV. CONCLUSION

The Department's purported rate study fails to examine any of the issues that must be examined under 42 U.S.C. § 1396a(a)(30)(A). The Department has therefore failed to comply with the Court of Appeal's decision, the Superior Court's writ and judgment, the State Medicaid Plan, and federal Medicaid law. The Department should immediately begin a new rate study that complies with its legal obligations. It should analyze reliable data from the correct decade to determine whether the rates are consistent with efficiency, economy and quality of care (*i.e.*, that they are adequate to cover the costs of efficient, economical providers) and to provide Medi-Cal beneficiaries with the same access to home health services as the general population in the geographic area.

Respectfully submitted,

Robert C. Leventhal
Foley & Lardner LLP
555 South Flower Street, Suite 3500
Los Angeles, CA 90071
213-972-4500
213-486-0065 (fax)

Attorneys for California Association for
Health Services at Home