Re: Budget Subcommittee #1
Health & Human Services
California State Assembly

November 16, 2005

AUDIO TRANSCRIPTION

Transcribed by:
SUSAN H. CAIOPOULOS
CSR No. 8122

Job No. 93993

48e8769e-55dc-40b5-9ebe-7118eccd0a9c

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CHAIRMAN DE LA TORRE: So our first panel is Stan Rosenstein, the Deputy Director for Medical Care Services at DHS. The topic is cost containment and availability of services in DHS.

MR. ROSENSTEIN: Good morning Mr. Chairman and members of staff. Good seeing you again.

CHAIRMAN DE LA TORRE: Good morning.

MR. ROSENSTEIN: Stan Rosenstein, I'm the Deputy Director of Health Services of the Medi-Cal program. With me is Diana Dukay, who is the Deputy Director of our audits investigations division. And when we talk about the fraud issues, Diana will take those over for us.

It's a pleasure to come here today and talk about Medi-Cal and what we've done on cost containment. Obviously we're preparing the Governor's budget now, and we don't have information yet on what we propose on the Governor's budget.

This is a good opportunity to look back and talk about what have we done over the last four or five years in terms of Medi-Cal cost containment. I've provided you with a few charts that I'll walk you through, because I think it's important to start with

what is the context in which Medi-Cal operates.

And Medi-Cal, like all Medicaid programs in the nation, provides healthcare coverage where other programs really stop. We provide it for low-income qualifying people who generally can't get the coverage anywhere else.

For example, a large portion of Medi-Cal expenditures go to people on Medicare. We cover the things for people on Medicare that Medicare doesn't cover. We provide coverage for people who have healthcare conditions where they can't buy private insurance on the private market. And we provide healthcare coverage for people who aren't employed or they have a job where there is no employer coverage. So we're asked to do some of the hardest things in healthcare coverage, because we do what other folks are unable to do.

We are subject to items that are outside of the control of the Medi-Cal program. Some things we can control, some things we can't. But we are subject to changes in employer-based coverage, changes to the economy, and healthcare inflation. As everybody knows, healthcare inflation is going up very extensively.

I would note the Medi-Cal cost of growth is much smaller than if you look at any other cost of

growth of healthcare coverage for like private employers, even the state employees healthcare system. Medi-Cal has been able to contain costs at a much better level than -- well, any Medicaid program or other healthcare coverage.

When you look at the other factors that affect Medi-Cal, a big factor that effects us is the lack of nursing homecare coverage, either on the private market or in Medicare. We pay -- 85 percent of our nursing homecare patients are on Medicare. Again, we're providing coverage where Medicare does not.

We also serve multiple roles. We serve as a -- obviously a major coverage for people to get healthcare. We also serve as a major source of federal funds for the safety net of California, hospitals, clinics. We are a major source of federal funds for the Department of Developmental Services, the regional centers, the major source of funds for the county mental health programs, and a major source of funding for the counties in the public health programs, in everything from public guardians to adult probation. So we serve multiple roles.

If I could ask you to turn to the pie chart. I wanted to show you, you know, where do we spend our money. I think it's very interesting to see the areas

that we spend money. And you'll note that the big expenditures are really nursing homes, hospitals and Medicare. If you look at Medicare, we pay -- if you combine the new clawback payment and the Medicare Part A and B buy-in, we're spending over $2 billion a year to the federal government to support the Medicare program. That's out of about $13 billion. That's about 13 percent of our budget goes to supporting Medicare.

If you look at, for example, just physician services, we only spend $520 million a year. So it shows you where the money goes in the Medi-Cal.

I'd also point out, in terms of Medi-Cal administration, if you look at the activities that we do for -- the administration of the Medi-Cal program is comparable to a health plan. Our administrative overhead is about a little less than 2 percent. If you were talking to probably any HMO and they said, "I was at 8 percent," they would be real proud of being at 8 percent.

My staff at ADS and the things we do comparable to a health plan are at 2 percent. So we're at about 6 percent below in overhead of what a health plan is:

We do spend quite a bit of money on intake to beneficiaries for county administration, enrollment in healthcare plans, which is a cost that we bear that, you

know, a healthcare plan doesn't bear. But we are pretty efficient, in terms of administration, as compared to the private industry.

Medi-Cal is a vital program. I want to talk about the caseload for a second. We now serve 6.7 million in California. One out of every six people in California are on the Medi-Cal program now.

And if you look at the chart I provided on caseload, you can see that we had a very large growth with the expansions in simplification of Medi-Cal, and we continue -- our eligibility continues to grow, not at the same rate.

What is notable is that the growth rate, it gets kind of lost in this process, is among people who are on SSI, the disabled population. That continues to grow very extensively in Medi-Cal. And that's notable, because they are high-cost individuals.

Also I wanted to show you the growth of the program between 1998 and '99 to today. Medi-Cal general fund costs has grown by 73 percent, over $5 billion. If you look at the chart, we tried to show you the changes. But you can see that, you know, since 2001, '02 to current day we've gone up by about $3 billion just in that time frame. And you can see that the slope is still upward. We're estimating we run about 8 percent

growth, between caseload and inflation, in the Medi-Cal program in annually.

I wanted to talk a little bit about the study that was done by the California Public Policy Institute. They did an independent study, and I know there's a little bit of controversy about it, but they estimated a growth rate of about 8 1/2 percent over the next ten years. That's pretty comparable to what we see. I know the LAO thinks it's a smaller growth rate. And, you know, we could debate the growth rate, but kind of the -- I think some of the findings are still significant either way. But they did say, you know, our general fund, $13 billion, would grow to $19.7 billion general fund in 2010, and $29.1 billion in 2015.

Most notably, we would grow from 15 percent of the budget -- Medi-Cal is the second to largest item general fund in the budget. Education K-12 is the largest. And we're 15 percent of the general fund now in the budget, and they projected by 2015 we could grow to 21 percent.

Lastly, and most importantly I think in what they found is that -- and this is not news, but it's important for people to recognize, is that the cost of care in Medi-Cal per person varies very dramatically. We spend about $800 a year on a child. And for somebody

who's 20 to 30 years old we spend about double that, about $1,600. For the average 85-year old, who is typically covered by Medicare, we spend over $10,000 of expenditures. And what we're seeing is an aging population, which means Medi-Cal will be more expensive.

Also notable is that the most expensive 2 percent of our enrollees, just 2 percent of the people in the program, account for 40 percent of our fee for service expenditures. So we're spending almost, you know, 40 percent of our budget on a very small set of our population. And the bottom 75 of the enrollees account for less than 6 percent of our costs. So there is a very dramatic difference.

We looked at why are the most expensive people so expensive. And the bottom line, what we discovered is they're expensive because they have high-cost medical needs that they need. They are people who are at the end of life. They are people who have had a major medical encounter, a transplant, a trauma in a car accident, or some other major trauma. They're people in nursing homes. They're hemophiliacs. And these are people who are very sick and have very high-cost services, which makes it very challenging in terms of managing costs, because these are people who are ill and need the services.

We also know that about 40 percent of our expenditures for disabled population go to people who are mentally ill, who have comorbitities that are healthcare related, so they're -- you know, in addition to mental illness, they're either asthmatic or diabetic. And what we do see in that population is while their mental illness is being treated, many of them do not have primary care doctors treating their other chronic healthcare conditions.

Word is, as you requested, to talk about the budget reductions that have occurred over the last four years. I should point out that these budget reductions were really a combination of changes that were made under Governor Davis and under Governor Schwarzenegger. So when you look at a four-year picture, we're crossing over two administrations. And these are itemized in the charts that are attached. And I was going to try to attach them in more global areas and not go through every one in detail, and I certainly can if you'd like to.

And eligibility, which is a major factor, again, we've added 1.7 million people to the Medi-Cal program. There has been a strong emphasis, in the budget cuts that have gone over for the last four years in Medi-Cal, to maintain eligibility.

If you look at the list of changes, there was only one of them on there that actually rolled back an eligibility category, and that was a small, 2,000-person, state-only program for transitional Medi-Cal that was reduced I think in 2003, and that was the only reduction. So of the 1.7 million people growth, the only eligibility reduction was small, over 2,000 people.

We did implement some changes to improve how -- on how eligibility was determined. In 2003 we imposed what's called a midyear status report. Medi-Cal had gone from very complicated quarterly status reporting to annual reporting in order to help contain costs. The legislature enacted, and we implemented in August of 2003, a new midyear status report where parents submit their report, and it's a very simplified report.

We've also implemented a couple changes in county processing that are on the eligibility list, to make sure that the counties were timely processing both redeterminations and new applications, and to make sure the Los Angeles County was properly telling us when people were disenrolled from the program.

We had a computer glitch that actually had about 160,000 people who were ineligible still showing eligible, and we fixed that. And just to make sure

that, you know, the systems are working, making the eligible people eligible and getting ineligible people off the program.

And that is the extent of the eligibility changes that we've made.

CHAIRMAN DE LA TORRE: Stan, if I can interrupt. You keep saying 1.7 million. The chart you gave us with the Medi-Cal average monthly eligibles shows an increase of only about 800,000. So it's from 5.9 to 6.7.

MR. ROSENSTEIN: Yeah, I was giving 1 point -- I started at an earlier base year.

CHAIRMAN DE LA TORRE: Okay.

MR. ROSENSTEIN: That's the difference. That chart doesn't go back to '99. I started at '98, '99.

CHAIRMAN DE LA TORRE: Okay.

MR. ROSENSTEIN: This chart only goes back to --

CHAIRMAN DE LA TORRE: To '01, '02.

MR. ROSENSTEIN: Right. And when we ended the implementation -- or when federal Medicaid welfare reform came in, and that was actually in 1998, it was kind of the benchmark where Medi-Cal became unlinked from Cal-Works, or AFCC at that time. We had 5 million people on Medi-Cal. So that's the base year that we

typically go back to, and that's 5 million to 6.7.

The federal Medicaid reform really dramatically changed Medicaid in general, and in California, the Medi-Cal program.

CHAIRMAN DE LA TORRE: Okay. Thank you. Continue.

MR. ROSENSTEIN: The next area I was going to talk about was pharmaceuticals, prescription drugs. This is an area of great interest to everybody. I'm proud to say that California actually leads the nation in cost containment in this area. We have a very good formulary. We provide people with every drug that's FDA approved. Some with prior authorization, some without. People can get the drugs in the Medi-Cal program that they need.

We do use our market influence very extensively to get additional rebates from drug manufacturers. We get about ten times the rebates of any other state, and it's about -- it nets us about $600 million a year in rebates. That's all going to change with Medicare Part D, because 55 percent of our program goes away. But we so far believe we'll continue to be successful.

We do what is called therapy category reviews, where we take a category of drugs, and we have manufacturers compete against each other to stay on our

list of contract drugs. And we're very successful in getting a good price, and actually very successful in keeping most of the drugs in the formulary, so that most drugs are still available without prior authorization of Medi-Cal.

We have implemented new limitations on some of the misused drugs, Serisun being the biggest example, which was misused and sold to bodybuilders. We had a major fraud program there that we've now shut down.

We have led the nation in trying to -- in working with the attorney general on this, and we want to give them a lot of credit on this, in trying to reform what has been a fraudulent practice of reporting drug prices, what's called AWP, average wholesale price, or also known as "ain't what's paid," has been the prices that we've paid in the past.

And California, two years ago, went forward and became the first state in the nation to move away from that pricing structure. That is now what Congress is looking at doing nationally, and we're very supportive of that.

We believe two things: One, we ought to pay honest prices to pharmacies for honestly reporting, and then we ought to pay the pharmacists their value in dispensing. So part of what we did was we raised our

dispensing fee.

We have taken action to control the misuse of medical supply items. This is somewhat controversial, because for some people that made it a little harder for them to get these drugs -- or get these products, because it required prior authorization.

But what we were seeing was some providers would just ship large volumes of these products to people whether they needed it or not, and we were just spending a lot of money to stack up products in someone's garage. And so we put some utilization controls on, so that people could still get the products, but we wanted to make sure it was medically necessary.

We looked at areas where we pay providers too high, at least from our perspective. You hear an awful lot, and you'll hear an awful lot in a few minutes, about where we pay providers too low. But there were areas of Medi-Cal where we thought we paid too high of reimbursement rates.

We targeted laboratories as one of those areas. We went to paying laboratories at 80 percent of Medicare rather than some of the rates that we were paying. We made substantial savings, and I might add that we didn't lose any laboratory services in the process, didn't

create any access problems.

We looked at the area of durable medical equipment, which I'm sure you'll hear quite a bit about later. And we looked at that as being a high-fraud area, and it was also an area chronicled by the Los Angeles Times, that we were paying, you know, basically list prices for very expensive wheelchairs, and it particularly focused on that.

So we tried to come up with a pricing mechanism to make sure that the equipment was available, and yet at a more reasonable price. We're still doing work on that area.

I would point out, as you hear about these issues, we didn't lower our price on wheelchair repair. We are looking at whether that needs to go up or not. But we did not make a reduction in that area. But we did make a pretty substantial reduction in what we paid on DME items, to get it more in line with, you know, really what the commission market was doing.

We spent a lot of time on our dental program. We're one of, I think, six states in the nation that offer an adult dental program. It had been a very high-cost growth area, and it also turned out to be a very high fraud area.

I don't know if you recall or have seen any of

the -- like where we were on The Today Show, where people were being brought in by what they call cappers, paid to come in and get Medi-Cal services, and then they would treat them by nonlicensed professionals and given unnecessary services, sometimes in very, you know, painful manners.

We couldn't tolerate this abuse, and so we implemented a new requirement, it came out of one of the special legislative bills, to require x-rays for anybody who had four or more cavities filled in a year. So that if somebody had a high, chronic need, we wanted to make sure that they really were filling, you know, teeth that really needed to be filled, and they just weren't doing what the -- you know, quick fillings to make profit on people.

We would see kids come through who had, you know, no problems with their teeth, and they would come out with 11, 12 silver spots on their teeth where somebody had filled their teeth to bill the Medi-Cal program. And that was just intolerable. The legislature adopted and we took action, and we actually had a pretty strong reduction in payments. We think with x-rays, you know, necessary cavities can be filled.

Last year as part of the Governor's redesign proposal we established an $1,800 dental cap, you'll

recall that was adopted.

Another area that we've taken action on, that we've seen a tremendous growth, is in the adult day healthcare centers. There are many adult day healthcare centers in California who do wonderful work, who keep people out of nursing homes. And, you know, God bless them. They are the greatest thing in the world. There are also some people who have taken advantage of this benefit and have created centers that don't provide healthcare benefits, are little less reputable.

We spent a lot of time on that issue. From an honest perspective, this is a program that needs reform. We've got significant federal concerns, we have state concerns. What has happened is we have a moratorium on enrolling new providers. And we need to get this program reformed so that we can pass the moratorium and allow the good facilities to expand.

One of the things that Medi-Cal does, and we emphasize this in cost containment, we had a pretty substantial proposal last year, we were in front of you on it, is try to get other people to pay the healthcare costs when they're obligated.

Medi-Cal is the payer of last resort. We pay only -- we only pay after private insurance pays. We believe -- you know, the law requires, and we believe,

that the government should only pay when nobody else can pay. So we do healthcare recoveries, cost avoidance, and we do a very extensive effort.

So we've made major efforts, supported by the legislature, to expand those efforts so that we can save money, have somebody else pay for the healthcare, and in effect we recycle that money back in the Medi-Cal program, reducing our general fund.

We contract with EDS. EDS is our fiscal agent. They process a lot of claims. They see lots of errors. We've incentivize them to find these errors and bring it to our attention. This year alone EDS is going to save us $7.6 million general fund, federal government same amount, through their efforts to identify areas we can, you know, improve the program.

And lastly, in terms of cost containment, a very important component from a Medi-Cal perspective is better utilizing federal funds. Medicaid has become the largest source of federal funds in state government. So we've done an number of things over the last four years to improve -- in actually the last couple of years in particular, to improve the federal funds we get for the Medicaid program.

We proposed last year, and the legislature adopted, an SCHIP option to get federal funding for

prenatal care in the Medi-Cal program. We've implemented, for the first time, three provider fees or taxes to assess on providers that allow us to use rate increases. We increased rates for ICFDDs. We increased rates for AB 629 for nursing facilities, a quarter of a billion dollars more money for nursing facilities a year. And we increased reimbursement for our managed care plans through assessing fees that then, under Medicaid, are allowed to use those providers fees for provider rate increases and enhance their revenue.

We've had major efforts with our sister department, Developmental Services, on expanding their waiver, and brought in additional money. A year ago we had the IHSS waiver approved, that brought in substantial new federal funds for the Department of Social Services through Medicaid. The hospital waiver, while controversial, did bring in over $200 million a year of new federal funds for the hospitals.

Lastly, let me talk about provider rate cuts -- or rate issues, which is the last item on your agenda.

We have, based on the legislation that was passed this year, a 5 percent provider rate cut coming for many provider types. It's still -- the court action is not yet resolved, so right new we're stayed from implementing that. But if the stay is lifted we will go

ahead, pursuant to the law, to reduce provider rates by 5 percent, effective this January 1.

As you can see from your review of the data, if you look at the sheets that we provided in our charts, in 2001 we gave a very substantial rate increase, about a 16 percent. That was the first substantial -- and probably the first and only substantial rate increase we've given since 1985. Typically, if you look year after year, Medi-Cal provider rates have been frozen, with the exception of nursing homes and hospitals. But for physicians and other provider types, they really have seen, you know, one comprehensive rate increase in 20 years now.

The other place we were at with our health plans. We value our health plans, as well as our providers, very heavily. Our health plans have -- with a few exception, have had frozen rates for the last four years, and in some cases we've reduced their rates. So we have, you know, not been very generous in our rates to either our health plans or providers, I guess would be perhaps an understatement.

But that's been an area that historically, in the last 20 years, the state has said if we have money, we want to provide it on coverage, covering more people, rather than provider rate increases. And you can see

that when we've invested money in Medi-Cal, by and large we've invested it in the expansion of the program.

Let me turn this over to Diana Dukay, and she'll talk about our fraud efforts.

(Portions have been omitted.)

MS. BIGLIERI: Mr. Chair and members, my name is Barbara Biglieri. I'm with the California Association for Health Services at Home, and we're in the provider section. But I'm here today because we had a member of a child who receives Medi-Cal services through the home health benefit, and unsettling as it is, she was not able to attend today because her nurse couldn't make the shift.

So it's kind of a poignant statement that here she was going to come today to tell you how important it was that her son receive these services from a home health agency, and how important it is for a family, it keeps her with her family, allows her to work, not go on Medi-Cal herself, and she couldn't arrive, she couldn't come today.

So we provided the statement, all of the statements with our provider groups will come up later, along with the mothers. But I think it's especially cute and poignant that she couldn't come today because she was staffing the case for her son because the nurse

couldn't make it because the provider rates are insufficient.

But her statement is compelling, and she goes into great detail about her son. But I'll let you read through it, unless want to indulge me for one more moment.

I think it's important to note that he's six years old and suffers from a rare brain condition. He requires a ventilator to breathe, a hospital bed to sleep, and a feeding pump to eat. Until he was two years old he was in an ICU every day, that's an extreme cost, at UCD, to Medi-Cal.

And as a result of August 2000, when the rates went up 10 percent, they were able to find an agency that could take him. And now he's been at home. He's only had eight days where he had to go back into an ICU.

And I think that's a critical statement about when you can serve someone in the home, they wouldn't have to be served in an ICU, and it would save money.

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

And the last point is that she feels extremely

lucky that she is gets services, even though they're not staffed. She's going on her fifth night without having a nurse to take care of it. And she knows that she needs to work in order to get the insurance for the rest of her family, so that they won't go on Medi-Cal.

So it's an important statement, and she wanted to be here to say it, but she couldn't. So that's why we're here.

CHAIRMAN DE LA TORRE: I appreciate that. Thank you.

(Portions have been omitted.)

MR. HATKENSCHIEL: Mr. Chairman, Joe Hatkenschiel with the Home Health Association.

Earlier you received a chart that showed the 10 percent increase that home health providers received in 2000 and 2001. This is the only increase we have received over the last decade, during a period where CMS says home health agency costs have increased 42 percent.

Today our representative would like to speak to the availability of home health services from two different perspectives: The perspective of a hospital discharge planner trying to place a patient in home health, and the perspective of the home health administrator trying to deliver the services to the beneficiary.

MS. PENNY: My name is Kate Penny, and I'm a registered nurse, and I'm a board member for Northern California Case Management Society of America. I'm also a manager for the case management department at Sutter General Hospital located in downtown Sacramento. I've been working in this position for five years with Sutter, and I have 15 years experience as a case manager, both in acute care settings and HMO and insurance.

My RN staff provide discharge planning for our Medi-Cal hospitalized patients to return back home, with either home health agency or without, and also into nursing homes.

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.

MS. LEECH: I'm Barbara Leech. I am the director of case management for Sutter Memorial, Sutter General, Sutter Davis Hospitals as part of the Sutter system. I'm also a part of the Case Management Society of America and a number of other professional organizations looking at these issues.

As the administrator for these departments, I receive regular briefings from our hospital home health agencies and discharge planners that I supervise, and the issue is always the same. We can't find places for

our Medi-Cal patients to go to take care of our patients.

Our hospital's affiliated home health agency, who we interface with regularly, have home health liaisons in our hospital, and they spend their days calling agency after agency to try to find resources to take care of our patients. The result is usually is the same, and that is that the patient remains in our hospital, with all of the risks and costs involved in acute care. This, of course, occupies a bed that could be used for more acutely ill patients.

And I know that the Assembly is aware of the ED diversion issues in our community by the backup of patients within our facilities.

Hospitals track data on why they can't discharge patients. We don't always know the specific reasons why, however. But it's my experience that the reason why is because the patients require an extremely high level of care that our agencies can't afford. The description of the six-year-old today on the trach vent is a very good example of the kinds of patients that we are trying to place. Insurance doesn't cover the needed services. And the most frequent case is that the home health agency says, "I cannot afford to take this patient on."

The bottom line is that the patients could be managed by home with significant home health agency support, but they can't take on our clients because of the cost.

I hope that you'll be able to help us and assist in moving our patients through the system to help benefit our acute care facilities.

CHAIRMAN DE LA TORRE: Thank you.

MS. DALTON: My name is Melissa Dalton, and I'm a nurse administrator for Trinity Care, a licensed and Medi-Cal certified home health agency. My two offices provide home health skilled nursing services to three counties: Los Angeles, Orange, and Ventura County.

There are two types -- I want to clarify. There's two types of home health agencies. There's intermittent visits home health agencies, and shift cared nursing home health agencies.

Our home health agency specializes in providing shift cared nursing to children and adults who are dependent on technology, whether it's a ventilator to breathe or a gastrotomy for feeding.

Our beneficiaries participate in the Home and Community Based Waivers, EPSDT that is authorized through CCS, Department of Health Services, and through our regional centers.

Our services allow the dependent child or adult to remain at home, and the patient or caregiver to work, while the nurse, typically an LVN, provides the required skilled nursing services.

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.

The shift nursing program and the Medi-Cal benefit is all across California. Therefore, the impact is potentially extensive. I was alarmed about the

potential 5 percent rate cut, as we have been, and that's why we fought it. We're currently struggling now, and that would pretty much close our doors.

CHAIRMAN DE LA TORRE: Thank you.

MS. TURNER: Mr. Chairman, I'm Sharon Turner. I am the nurse administrator for Sierra Nevada Homecare. Our agency is a certified Medicare, Medi-Cal home health agency serving Nevada, Yolo, Yuba, Sutter, and parts of Placer County.

I'm a registered nurse, and I have worked -- had the privilege of working in home health for the last 30 years. This gives me a unique perspective in terms of the impact of the stagnant Medi-Cal rates, and both on our Medi-Cal home health providers as well as on our nurses and our patients.

I also chair our state association, CASA's, Medi-Cal committee, and have done that for number of years as we work through trying to implement just changes that would maybe make things more efficient for our providers.

Our agency provides care in what is called a part-time intermittent basis. We are providing care in the home, we make the visit, and then we leave. We are not in there for an extended periods of time, such as my colleague Melissa is in her part of the home health

agency.

Typically our patients are transferred from acute care hospitals, from skilled nursing facilities, and from physician's offices, in order to avoid a costly hospitalization or emergency room visit.

During a visit the family -- as the professional makes the visit, the family is also educated and trained to do part of the care when we are not there, because we are not there 24 hours a day. But we are teaching them to do their ongoing care and monitoring as best we can.

There are daily visits that are often required because the care is too acute for an individual to learn, and yet we can have them at home and not have them placed in an acute facility.

Home health visits are an appropriate way to monitor care, to assess if the patient's condition is improving or worsening, and to keep the patient, again, out of a more restricted, a more costly environment.

If the care or the patient's condition changes, the nurse is working with their physician, because all of our care is under a physician, a physician's order. We are working to modify that care and make adjustments as we go.

The involvement with the M.D. is very, very

critical. Because as we heard from our colleague from the medical association, the access to the Medi-Cal provider is very, very limited. So those visits that a beneficiary may have to make to a physician can be very, very limited. So that if we can work with the physician, we can limit and improve the access by having our skilled eyes and ears in the home and working with the patient.

Home health is an excellent form of managed care. With the nurse overseeing the total plan of care under the direction of the physician, we can really look at being able to monitor what care is being rendered and the appropriateness of that.

I wouldn't have been or remained in home health for the last 30 years if I hadn't felt really, really strongly about the benefit to the patient and to the system as a whole.

Our patients and people in general do not want to stay in institutions. They want to be able to have access to the home environment. They want to be able to be home to recover, to rehabilitate, and if they choose, to die with a great deal of dignity, with those who care the most about them surrounding them.

Just to give you an example in terms of cost-effectiveness of homecare, a Medi-Cal beneficiary

who received, by chance, a home health visit every day, let's say for daily antibiotics, would cost about $2,200 a month, versus -- at our current reimbursement rate. That same Medi-Cal beneficiary who is in the acute care or hospital because they couldn't find that home health agency to take care of them would cost approximately $30,000 for that same month of care, at $1,000 a day. And that's a conservative estimate in terms of what the cost of that care would be.

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.

We ask that you examine this rate for community-based providers, and that you will consider an increase, and, God forbid, not the decrease that has been kicked about.

These programs help our families and

beneficiaries maximize the quality of life in a way that provides cost savings to our state. We believe that homecare can be part of the solution for some of the high costs of care. And if more beneficiaries were enrolled in home healthcare, they would avoid emergency room visits or more acute episodes of care, and they could be treated at home. Thank you.

CHAIRMAN DE LA TORRE: Thank you Sharon.

* * *

I, the undersigned, a Certified Shorthand Reporter of the State of California, do hereby certify:

That the audio recording was listened to and taken down by me using machine shorthand which was thereafter transcribed under my direction; further, that the foregoing is an accurate transcription thereof.

I further certify that I am neither financially interested in the action nor a relative or employee of any attorney of any of the parties.

IN WITNESS WHEREOF, I have this date subscribed my name.

Dated: _____

_____

SUSAN H. CAIOPOULOS
CSR No. 8122