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DEPARTMENT OF HEALTH CARE SERVICES

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TIFFANY C. KRAFT

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APPEARANCES

HEARING OFFICER JOHN MENDOZA

PUBLIC COMMENT

Mr. Dave Dial, Pro-Care Home Health

Mr. Jarrod DePriest, Maxim Healthcare Services

Mr. Ken Erman, Rx Staffing & Home Care

Mr. Jason Grinstead, Care at Home

Mr. Robert C. Leventhal, Foley & Lardner, LLP

Mr. Henry W. Zaretsky, Henry W. Zaretsky & Associates, Inc.

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PROCEEDINGS

HEARING OFFICER MENDOZA: Good morning, everyone. My name is John Mendoza. I'm Chief of Fee-For-Service Rates Development Division. Welcome.

As you're aware, the purpose of this hearing is for you all to present comments on the Department's further rate review of home health agency services which is noticed in the California regulatory notice registrar on March 15th.

You may present orally. You may also present written comments, which we can share with our reporter and with the Department.

Witnesses presenting testimony will not be sworn in for the purposes of today's discussion. For your presentation, there will not be a discussion on the issues you present. Again, the purpose specifically is to hear your comments related to the most recent report.

The entire proceeding is being recorded. And anybody wishing to obtain a copy of the transcript may contact my division. And the e-mail address and mailing address are noticed in the notice concerning this hearing.

Now, because we have such a small room and no microphone available, we ask that you, if possible, either stand up when making comments or come to the front table. And if we are having difficulty hearing, we'll let you

know so that we can voice our comments a little bit more loudly and clearly.

When you are called to speak, please share your name. And if you are representing a organization, please share your organization as well. And if you could give our court reporter your business card with your name on it, that would be very helpful.

Now at this point, you are given an opportunity to present your comments. I think we have our first speaker here. There is no time limit for your comments. Thank you very much for being here.

MR. LEVENTHAL: Thank you, Mr. Mendoza.

I'm Robert Leventhal from the Law Firm of Foley and Lardner. I represent the California Association for Health Services at Home.

I've reviewed the report that the Department created, and this is the second report that was once again ordered by the California Court of Appeal. And unfortunately and very distressingly, it appears very clear from the face of the report that the Department has not done what the court ordered it to do and has not complied with either the court order or with the statutory comments -- statutory requirements.

In fact, the Department continues to rely on many things that the court of appeals expressly stated did not

form a reasonable basis for the Department's conclusion and has ignored its own data that it presents in the report and claims to reach conclusions that are the exact opposite of what the data that the Department relied on show.

I'm going to begin my comments by talking about the conclusion to the Department's report. And the first sentence in that conclusion reads, "The percentage of HHA users out MediCal fee-for-service eligible population during 2001 to 2005 was favorable when compared to the percentages during the 1992 to 1997 period considered in the 1998 study which determined there was sufficient access."

So here from the get-go, the conclusion is based on the same study from the wrong decade that the Department -- that the Court of Appeal expressly ruled was not an appropriate basis for the Department's conclusion.

However, the sentence is even more problematic. Not only is it relying on a source that the court already said is not appropriate to be relied on, it misstates what that source held. The 1992 to 1997 study, which was performed by Tucker Allen, relied primarily for its access conclusions on the fact that utilization doubled during the period studied in the study. The amount of users per eligible person was 0.13 percent at the beginning of the

study period, the first year of the study, and had gone up to 0.2 percent by the final year of the study. So Tucker Allen said we think access is adequate because the utilization as measured by the ratio of users to eligibles doubled during the period during the study.

In the years 2001 to 2005, if you look at the Department's own data that is contained in its supplemental study that we're here to discuss today, you'll find a mirror image of what happened during the Tucker Allen study. The numbers went from 0.24 percent down to 0.19 percent. So instead of having an increase, a doubling, you have the number going down by 24 percent.

And so the very first sentence here shows there is a lack of credence to what the Department did, a lack of reliability. It continues to rely on the study it was told not to rely on. It misstates the results of the study by claiming that the data from 2001 to 2005 are more favorable than the data in the study. It ignores the Tucker Allen bases and conclusion on the doubling of utilization and ignores the fact that the 2001 to 2005 time period had a 24 percent decrease in utilization and was, in fact, a mirror image of what happened in the study.

To the extent that Tucker Allen's conclusion and reasoning that an increase in utilization supports a

conclusion that there is adequate access, the decrease that occurred during 2001 to 2005 supports a conclusion that there is inadequate access. So using the own Tucker Allen approach and its own reasoning and applying that to the 2001 to 2005 data, the Department had no choice but to find that there is a problem with access because it was significantly decreasing during that period and was not increasing as it did during the Tucker Allen study.

Then if we go down, the next fact that's discussed in the conclusion section is a statement that "The number of HHAs participating in the MediCal program increased steadily by 7 percent from 419 in 2001 to 449 in 2005." And again, this is part of reasoning that was discussed by the Court of Appeal in its decision. It is true that the -- there was the 7 percent increase in participating providers in MediCal. However, you had four times that in the Medicare program during the same time period. And in fact, the difference between the number of agencies that accept MediCal and the number of agencies that accept Medicare doubled during that time period.

And so if you're looking at the number of agencies that participate in the MediCal program, this, the Court of Appeal expressly stated on page 18 of the appellate decision, the slip opinion, would cause any rational person to believe there is likely a problem with

access, because you have this huge gap in number of providers that accept the MediCal program. And the gap has significantly increased during the period under study.

So once again, the fact that this has continued to be relied on shows the Department has not listened to what the Court of Appeal said and has not correctly analyzed the own data that's before the Department.

The next mistake that's contained in the conclusion section is a reference to the units of service that were provided during the time period in question. And the Department claims that the units of service went up, and this supports their conclusion that there is no access problem. However, units of service is defined as claims. And claims is simply whatever a provider chooses to include in a single bill. So if a provider provides fewer services, but bills more frequently, there will be an increase in claims and, hence, an increase in units of service. So units of service, since it's something that's arbitrary and just based on how services is billed, is not an appropriate measure for the Department to have relied on.

Furthermore, the fact that there are more bills being sent more frequently, each of which is for less money than during the earlier period, the fact that the bills are coming more frequently for smaller amounts

demonstrates that there is most likely an issue with the rates being inadequate, because it's causing providers to have to try to increase their cash flow in order to offset to some extent the damage that it's caused to them by the fact that the rates are not sufficient to cover their cost of providing services.

So not only is units a meaningless measure, but to the extent it has any meaning, the data would tend to show there are cash flow problems that providers are suffering because of the inadequate rates and are there for billing more frequently for smaller amounts.

The next mistake that the Department makes in its conclusions is it looks at the number of beneficiaries of each program, Medicare and MediCal, to home health agencies. And this again is a meaningless measure because all it takes to become a MediCal home health agency is to fill out a form. So if you are already in business as a home health agency, it's very easy to become a MediCal provider, whether or not you intend to provide many or even any MediCal services.

And there are, in fact, a number of MediCal agencies that don't provide any MediCal services. So just looking at the ratio of enrollees to home health agencies or the ratio of eligibles or even users to home health agencies is basically irrelevant because being a MediCal

home health agency does not mean that you've agreed to provide services to every MediCal patient that asks for services. It doesn't even mean that you've agreed to treat a single MediCal patient. It just means you've signed up for the program. And in the event you need to bill the program, you have the credential that's required to be able to do that.

And in fact, the Department's own data shows that home health agencies that treat MediCal patients, 31 percent of them have less than 60 visits a year. Whereas, home health agencies that are Medicare home health agencies, less than one percent of them had less than 60 visits a year.

So this shows that there is an access problem and it shows it's unreasonable to simply count the number of agencies that checked the box or filled out a form and signed up to be MediCal providers. What needs to be done is to actually look at access. Look at patients. Do MediCal patients who need treatment -- home health treatment get it? Do they get all the treatment they need? Do they get it as easily as Medicare or as other patients in the community? Those are the things that need to be looked at.

But each of the facts that are discussed in the Department's report and each of the facts that are relied

on in the conclusion are either irrelevant or support the opposite conclusion and actually demonstrate that there is an access problem.

Now, in the report, the Department has a bunch of speculations. They say maybe any differences in access are caused by this or maybe they're caused by something else. Well, anyone can speculate as to causes for issues. The Department wasn't ordered to dream up speculative explanations as to why there might be an access problem or why data that make it clear that there is an access problem could be erroneous. The Department was ordered to do some sort of study. That means you have to look at the actual data and see what's going on. Not just speculate. I mean, anybody could say maybe they're not using services because no one is sick this year.

I mean, it's possible. But that's not enough. There has to be an analysis. There has to be data. It's not just guessing. And here, you have data. Every piece of data relied on in this report or mentioned in this report supports there being a very serious access problem to a type of service that is really, really necessary for many very, very sick people, including children that are home bound and on ventilators that don't want to be away from their family, costing the State twice as much as what it would cost to have them treated at home by a home

health agency.

This is something that can ruin people's lives. And it deserves a serious analysis to make sure that these people that are desperately in need of care are getting the care they need. It needs more than just guesses as to maybe there is not a problem. It needs more than taking a Tucker Allen study that showed increasing in utilization and saying, oh, that's very similar to the current situation where you have the decrease in utilization.

I mean, that really is inappropriate for something as serious as this for people. And this Department has been given the trust of the State and put in a position where people's lives and the quality of their lives are at stake. And these sorts of games with data and writing reports that show an access problem but pretending you don't see it is really, really inappropriate for something this serious.

Now getting back to what the statute requires, the statute is very clear language that requires that the access that MediCal beneficiaries receive be the same as the access that this general public in the geographic area gets.

So this requires the question to be answered to be is the access equal? Do they have the same access? It doesn't require you to compare to what was going on in

1992. It doesn't require you to compare what was going on in 2001 and see how it changed. What it requires you to do is look at what access MediCal patients have, not how many agencies signed up but don't provide services, but actual access.

So if you have a beneficiary of MediCal and they need services, the question answered is, are they as likely to get it as a member of the general public and to get it as easily as a member of the general public. Can they get the services they need, the full extent of them, to the same extent as a member of the general public. It's a very simple question, and that's what needs to be looked at.

And if there are difficulties in getting access as the data that the Department did look at clearly establishes, those need to be addressed. And they need to be addressed by setting a rate that's sufficient to enable the beneficiaries to get the access that they are entitled to get under the law.

I mean, the Court of Appeals specifically talked about the fact that the number of agencies that do Medicare versus those that do MediCal, the gap doubled between those. And that there was a much bigger growth in Medicare agencies than in MediCal agencies. And the Department hasn't addressed that. They haven't looked at

the numbers. They haven't explained anything. They have some speculative things saying maybe someone got other services instead. But that's not enough.

What they need to look at is did people who wanted these services and were entitled to them, were they able to access them or not? That's what needed to be looked at. And that was not looked at. And they also needed to be looked at as why is this gap widening? Why is Medicare agencies growing at a faster pace than MediCal agencies? And that again was not looked at. There was no analysis of that.

The Department ignored its own data. As I said before, the users of home health services is down as a percentage of eligibles, down by 24 percent during the 40 year period at issue. That's a significant decrease. And when you compare that with the Tucker Allen study, which said there was access because it had a significant increase in this very same ratio, that's something that needs to be looked at. You can't just say, well, when the ratio is helpful to their being access, you can't say, well, that's a good ratio to rely on. But when the ratio shows a lack of access, a significant drop in access, to just ignore that fact and somehow pretend the data for 2001 to 2005 are the same as the data for '92 to '97 when one had an a significant increase and one had a

significant decrease. The expenditures per eligible person are down 9.4 percent. And so just looking at the amount spent is irrelevant. You have to look at the amount spent per eligible to see which direction access is going.

Access is based on who is eligible for services, and the amount spent is pretty much irrelevant, unless it's looked at in conjunction with the number of people that were eligible for services.

The fact that the gap between MediCal and Medicare went up is significant that they're double the agencies that don't treat MediCal that treat Medicare, that there was four times greater growth in Medicare licensed agencies. That's a very important fact.

The fact that 31 percent of Medicare agencies provide less than 60 visits a year, while less than one percent of Medicare agencies provide less than 60 visits a year. That's a key fact. It shows a lack of access, a tremendous discrepancy between the treatment that a patient will get if they are under Medicare than what they'll get when they're under MediCal.

So basically, the things that the Department relied on, the data it relied on, the hard data it relied on shows a severe access problem that got significantly worse during the period in question. And there is no way

that the Department can explain that, and the Department's made no real attempt to explain that. It's offered some guesses, without any data supporting them. And it hasn't really looked at what a day in the life is like of a MediCal beneficiary who's trying to access home health services or what the day in a life of a hospital discharge planner is like who's trying to place a patient -- a MediCal patient with a home health agency.

So basically, it's our position that the Department's own report convincingly demonstrates an access problem. Any rational analysis of the data there shows an access problem, access getting worse during the time period in question. The own techniques that the Department's experts Tucker Allen relied on for their conclusions in the wrong decade in the 1990s, if those are applied to the current data, they show an access problem.

So the Department really needs to, in my view, go back to square one. It needs to look at the data. It needs to acknowledge what the data unequivocally show. It needs to see there is an access problem, and it needs to figure out how much of a rate increase was required to get rid of that access problem, so that MediCal patients would have the same access as Medicare patients or as other members of the general public to the services in question.

And a rate increase for home health agencies

isn't something that's going to cost the State money. Most likely, it's going to save the State money, because having these patients treated at home by a home health professional is the most cost-effective way to have them treated. It's best for their quality of life and avoids hospitalization. It avoids serious complications. It avoids more expensive modalities of care, and it should not be withheld. It should be an important part of the treatment process, and they should be given the access that they're entitled to.

And the Department should look at this very, very carefully. There's seriously disabled children and other beneficiaries that desperately need these services that don't want to be institutionalized. It costs more to institutionalize them so it wouldn't even save the State money. The State needs to do what it's been required to do for all these years. And the lawsuit has been pending for over a decade. And this is the second time the State has had an opportunity to look at the data and analyze it correctly and come up with an analysis that's based on the actual data.

And what's happening in this report is basically that the State does a very convincing job of presenting data that clearly and unequivocally establishes a severe access problem that's getting worse rapidly.

To just bury its head in the sand and ignore the data and speculate that maybe it's not a problem because people didn't want the services anyway is not enough. It's not what the Court of Appeal requires. It's not what the statute requires. And it's not what MediCal beneficiaries in California deserve.

HEARING OFFICER MENDOZA: Thank you, Mr. Leventhal.

MR. ZARETSKY: Thank you. I appreciate the opportunity to present my opinions on the Department's rate review.

My name is Henry Zaretsky. I was retained by the California Association for Health Services at Home to assess the Department's rate review. I was also previously retained by the Association in 2008 to comment on the Department's earlier rate review.

I'm a health economist and a health care consultant based in Sacramento. My resume and my 2008 report are attached to my current report, which I submitted to you earlier.

While the data presented in the review show an access problem, the review ignores its own data and reaches a conclusion that's contrary to its own data. It claims that access is not worsened since 2001. It claims that access over the period 2001 to 2005 was sufficient.

And further, it claims that access compares favorably to data from the previous period. It sites data from its earlier report from an earlier study from 1992 to 1997 that showed an increase in access and said, well, that compares favorably to the 2001-2005 experience where starting in 2001, its users for beneficiary as an indicator of access, by 2001, the user's percentage of beneficiaries had already dropped from 1997. And then it dropped significantly further over the next four years. And it claims that compares favorably with the prior year. So that's saying something good compares favorably to something bad or vice versa or a rainy day compares favorably to a sunny day. It's a fundamental flaw in the analysis that the Department either fails to recognize or just erroneously puts in there.

The claims of the Department directly contradict the data presented in the review. As such, the review's findings fail to meet the statutory criteria, Section 30(a), which is what this is all about, and also what the appeals court ordered. Namely, that care and services are available under the plan to at least the extent they're available to the general population.

The analysis suffers from two crucial defects. First, the correct issue wasn't addressed. The federal statute requires a comparison of access between MediCal

beneficiaries and the general public, which the rate review did not address.

And secondly, the data presented in the review show worsening access since 2001 as opposed to the adequate access alleged. The review's own utilization data show expenditures per MediCal beneficiary and number of home health care users, which are patients, per beneficiary dropped significantly since 2001.

Further, the data underlying the review's comparison of MediCal and Medicare provider participation demonstrate worsening access for MediCal beneficiaries relative to Medicare enrollees.

The correct issue was not addressed. To comply with Section 30(a), the review should have compared access for MediCal beneficiaries with access to the general public. An access study meeting the requirements of this section would logically include analysis of MediCal beneficiary needs and those of the general public and the degree to which these needs have been met. For example, the length of time from a request for service, to provision of the service, difficulty in placing patients, and an analysis of unmet needs.

The Department has access to much of the necessary data involving MediCal, which could be supplemented with surveys based on sample of providers

addressing MediCal and the general public. However, rather than conduct a study that attempts to compare MediCal and the general public in terms of needs for service and the extent to which those needs are met, the review simply assumes that MediCal access as measured by utilization in the year 2001 is adequate without any analysis and then attempts to justify the worsening in access since 2001 shown by its own data through speculation and anecdotal observations.

The data presented in the review show that there has been a deterioration in access since 2001. And when combined with additional data readily available to the Department, the deterioration in access is even more pronounced. Based on the review's on measurement approaches, number of agencies available to MediCal beneficiaries, users per beneficiary, and expenditures per beneficiary, the review's use of the data it presented is highly flawed.

First, it uses number of claims, which are bills, as the measure of volume of service provided, while this is a meaningless measure of volume, since all agencies do not bill in the same manner. Some may submit a claim for each individual service, while others may submit a claim that bundles a number of services together. Some may bill based on an individual visit or a day's amount of services

or even a single hour, or they may bill once a week or even once a month for services rendered.

Given the cost pressures as the real value of frozen rates declines over time, agencies are under increasing pressure to maintain adequate cash flow and, thus, are likely to bill more frequently and less aggregated units. And this is borne out in the data. MediCal payments per claim have decreased over the 2001-2005 period.

It looks at expenditures, payments, which have increased slightly over that time period, but doesn't focus on total payments per beneficiary, which have been declining. And this points to worsening access. Clearly, the only valid measure of expenditures is on a per beneficiary basis.

Third, it tries to explain away the significant drop in users per beneficiary through speculative and anecdotal explanations. The explanations mainly involve observations and assertions that over this time period other programs could serve as substitutes for home health services and these other programs have expanded. Yet, it provides no data showing a shift away from home health to these specific alternative services and offers no reason why there should be such a shift.

More importantly, even if alternative services

are available, this does not indicate a lack of access to home health services if the beneficiary is entitled to home health services but cannot get them.

And fourth, it uses simple counts of agencies that have signed up for MediCal as an indicator of access without adjusting for the wide variation in volume among these agencies.

Once agencies with only token participation are taken out, the real number of available agencies has decreased over time. And this adjustment also shows worse and decreased access for MediCal beneficiaries relative to Medicare, contrary to the report's claims.

In addition to these crucial defects under the court's reasoning, the Department can show that MediCal beneficiaries had access to home health services equal to that of the general population, it could be assumed that the rates were not too low and then no consideration of cost would be mandated.

Since, however, the Department could not show this and, in fact, demonstrated the exact opposite, it cannot be assumed that the rates were adequate. Where an access problem exists, it is incumbent on the Department to attempt to determine the cause of the access problem. It is, thus, necessary to consider cost to determine if the access problem is due to inadequate rates.

Based on data presented in my 2008 report, which is attached to my current report, MediCal payment rates in 2005 were for most services less than half of cost. Given that nearly all home agency costs are variable, since they are overwhelmingly labor and travel related, agencies don't have the ability to spread their fixed costs over more patients whose payments are substantially below cost. Thus, their only means to maintain financial viability is to accept fewer MediCal patients, and thus limit access. If the Department believes rates were not the cause of the access problem shown by the data presented in its own review, it has the responsibility to offer and justify an alternative explanation, which it has not.

Thank you for given me the opportunity to testify.

HEARING OFFICER MENDOZA: Thank you, Mr. Zaretsky.

MR. LEVENTHAL: Should he give his report to the court reporter?

HEARING OFFICER MENDOZA: I'll take care of that issue later. Thank you.

Is there anyone else that would like to make a public comment?

MR. DIAL: Can you hear me okay from here? I do agree with the statistical aspects --

HEARING OFFICER MENDOZA: Can we get your name?

MR. DIAL: I'm sorry. My name is Dave Dial with Pro-Care Home Health Services located here in Sacramento.

HEARING OFFICER MENDOZA: Thank you.

MR. DIAL: Of course, after reading the report, I totally concur with the two previous commentors on the statistical inadequacies of the report.

But what I'd like to do is comment from the front lines from the point of a provider who has actually seen what's been going on and participated in it for over two decades. When we opened our agency, we opened it up with a primary focus of doing MediCal patients because we knew when we looked at the market at that time that there was an extreme lack of providers servicing the MediCal population. And we knew that by talking to discharge planners, physicians, and other referral sources to determine what we wanted to focus our business on.

Overwhelmingly, they said MediCal patients are the hardest to get home health services for. So we began to design an agency that could operate and function within the reimbursement rate for MediCal at that point in time, which was in the early '90s. As we did that, we knew we had a tremendous challenge based on just routine costs of having an agency, the cost of hiring nurses and all the other overhead costs building licensing, layers and layers

of costs that go along with doing that, some of which are fixed costs.

So as we started caring for primarily the medically fragile children in continuous care programs. We saw that for the amount of money that we were being reimbursed it was very difficult -- was our first realization to get enough nurses to fully staff these patients. Many times, these children we would be able to furnish part of what they were approved for services wise, but in some cases, we couldn't furnish all of the hours they were entitled to.

So to try to help disburse the cost of doing business, we started doing the intermittent visits. When we started doing intermittent visits and we contacted discharge planners that we were also focusing on intermittent home health visits, our phone started ringing. It range off the hook and never stopped ringing.

It was very easy to tell from them they were so appreciative that what we were trying to do as we were trying to do MediCal patients. They felt that literally we were an answer from heaven since nobody wanted to do MediCal patients. They were very difficult to place.

At that point in time, when we started our business, it was common consensus. So we rapidly became many discharge patients' best friend. We turned -- as

many patients as we tried to do, as much as we tried to staff up, as much as we tried to expand responsibly, we could never keep up with the demand of the MediCal referrals that were coming in. We were turning down at that time, 20, 30 referrals a week from MediCal patients looking to be discharged to home health.

So we were doing -- as we grew over the first few years, we were doing so many MediCal visits, tens of thousands a year, we actually had five dedicated MediCal case managers assigned just to our agency. We were doing a tremendous amount of volume.

As other rising costs came into play, the nursing shortage, if everyone recalls, that drove up the price of what nurses were making. We were trying to be competitive with that. It became more and more difficult to even hire the nurses to care for the patients at the reimbursement rate that MediCal was offering. Then you get hit -- we were hit with other increases in costs, whether it be the workers' comp issue that arose. We were very vulnerable to that kind of changing landscape when it came to regulatory burdens and the actual costs of doing business.

When we opened the agency, we knew what the regulations were. We knew that the State was obligated to do an annual rate review. And we felt early on, obviously naively at this point, that they would do what they should

be doing. They should look at what it costs agencies to do business, what it costs to reimburse an agency for the services properly to keep access to care up. And we thought in our mind from a purely honest standpoint that they would do that. That we would see rate increases as the years went on, because no one could imagine that somebody would believe that if you flatlined the rates, the costs are going up, that that wouldn't effect access. Because obviously at some point we can't afford to do the care anymore.

So we continued to do that care to the point where we could no longer afford to do MediCal patients. We, as I mentioned, did tens of thousands of visits a year. I don't know statistically many other agencies in this area, but I believe at that time we were one of the largest MediCal-only agencies in this area focused strictly on MediCal. I could be wrong. But I don't know the data from other agencies. But I'm pretty much not too many people were doing the volume that we were doing of only MediCal.

So when it got to the point where we had to make a decision on whether we can service continue to service the MediCal population, which was really near and dear to us and what we really wanted to do when we started our company, we were forced to make the decision that if we

wanted to continue to do any MediCal patients, we were going to have to grow into becoming a MediCal provide -- MediCare provider, rather, and doing other private insurance as well.

So once we were forced into expanding into Medicare to literally offset the losses that we were incurring in our MediCal patient base, we thought that not only is that unfair, that Medicare and private insurance is literally subsidizing the Medicare care that we're offering, but it severely limited what we were able to do for the population that we had set out to help.

We drastically reduced the number of MediCal patients as we had to ramp up Medicare in order to be able to service anyone. So that's exactly the route that we were not wanting to take, but were forced to take. We started doing more and more Medicare business. The referral services sources that we dealt with were so appreciative for so many years of what -- when we were doing the MediCal-only, we were doing such the volume of business that we were saving the State millions a year in hospitalization costs. A lot of money.

And during that period of time, we felt that, in exchange for what we were trying to do for that patient base and for saving the State money and to get the services where they needed to be serviced as far as the

people who are at risk for the payments in the hospitals if they're managed care, in return, we felt like the only appreciation we got was having people help us try to pull knife out of our back. We never got rate reviews. We never got any consideration. Every time we turned around, somebody was trying to cut the MediCal provider rated by ten percent or an already terrible rate was always threatened to become even worse.

So we felt betrayed, to say the least. We felt that we did our part. We stepped up. We tried to do what was right. And nobody else was doing what was right. The State was totally ignoring their obligation to do the annual rate reviews. We're not able to ignore all of our regulatory responsibilities. We're held to a very high tight standard. We're expected to be literally perfect in what we do in every juncture. And if not, we're penalized.

So for us to look and see an entity that is in control of the rates basically ignore the responsibility that they have to those same groups of people and the people like us who are helping alienated us to a great degree. We felt betrayed literally. So we cut our MediCal population down to about a third -- between a third and a quarter of what we were doing.

Now, with the volume that we were doing, we knew

that as soon as -- we ramped down very rapidly. Once we were able to ramp up the Medicare program quickly and ramp down the MediCal program, we knew those patients were not being absorbed anywhere. We knew that by the amount of repeat phone calls we would get from discharge planners over and over and over say, "Please, can you take one more? Can you do one more for us?" And it really tore us up to say no. But we had to if we wanted to stay in business to service anybody.

We, as an agency, a privately-owned agency, we put everything on the line for this company. We risked everything. And we couldn't allow our agency to go bankrupt because the State was not doing their responsibilities in rate reviews to keep up with the growing cost and our ability to do business. We felt like the State expected us, as a business, to subsidize the health care program for them by moving money around between Medicare and private insurance to subsidize their losses on MediCal.

The cost of doing a visit for us was around $140, as per our Medicare cost reports and the data that Mr. Zaretsky referred to earlier. We were getting reimbursed $75 from MediCal for the same service. That's half. And I don't think any reasonable person can imagine for a moment that a business that's continuing to lose money to

service a population that they're not going to stop serving that population to save a company and it wouldn't effect access. Those patients didn't just get absorbed by other agencies because the other agencies really weren't doing very much MediCal. A token amount here and there. But not fully focused on it like we were. It was actually -- I can still remember the comments of discharge planners, our case managers, and everyone when we voiced our necessity to ramp down our MediCal program. It was hard to handle, to say the least.

We always wanted to continue to do some MediCal patients because, again, that's where our heart was. It's easy to do Medicare. It pays appropriately. Nobody is going to get rich off of doing Medicare or any other health care service in home health. But you can make it work.

And for us to be able to service those MediCal patients, we needed to put it at a percentage where we could absorb almost a 50 percent loss of individual service by other payer sources, which means it costs us 140 to perform a visit. We're getting 75. We have the take 75 off of some other service that we're getting paid better for and we'll say or properly for which we'll say is Medicare. How much Medicare visits do we have to do in order to make up for that $75? If it costs us 140 to do a

visit and that's what we're getting reimbursed by Medicare appropriately, that's a lot of visits that you have to do to make up for the loss. If you ever actually make up for it. You're almost like you're rolling the stone down the hill hoping you can stay out of the way of it yourself.

So as time went on, we -- and I should say recently some of the managed care as the whole system turned over to managed care and now it's pretty much a requirement that the MediCal population chose a managed care, we're turned over to an entity being managed care that is for-profit. So whatever money was put into the managed care organization, which was the "pot of money" for a patient, the first thing that the managed care companies will do is, of course, look out for their profit line. So they'll strip away whatever that percentage is and put it into their pocket. Now the MediCal recipients actually have less of a pot of money for them to distribute for the services they're required to perform.

Our experience with MediCal managed care is, in many cases, one of their prime focuses in life is to figure out how not to pay you. How to get free services from you. How to allow you to perform services and then retroactively say, oh, you didn't get -- while we were waiting for the auth, we were performing services. And since we didn't get the auth, we can't abandon the

patient. We have to stay with the patient at all costs. So I can't begin to tell you how many times we were not paid for services because of some of the games that managed care played with us. Not only did we have the reimbursement problem, but now we have the aggravation and the extreme time-consuming process of having to deal with managed care and the issues that went along with that.

Recently though, in some ways, I'm glad to say we have found and worked with some managed care who finally came to realize that if you want to keep your hospitalization costs down, you're going to have to pay the home health provider a fair amount to reimburse them for at least the amount for the cost of what they're doing. And of those managed cares are now paying us almost double what MediCal is. And according to those entities, they're very happy because they have seen a huge drop in their hospitalization expenses. It's just rational thinking. Nothing happens without an equal or opposite reaction.

So I say that the smart ones are the ones that are realizing home health is being the last most affordable most efficient line of health care that exists, short of sending the patient home from a hip replacement with a do-it-yourself suture removal kit and a videotape. There is no other option.

We feel that we do a very good service. We do it very effectively, very cost efficient. And we expect and hope that the State do its job in reviewing the rates and making them appropriate, fair, and honest rates based on the data that's out there. Because I can sit here and tell you. I saw it. I lived it. I did it every day. To this day, we turned down 15, 20, 25 MediCal patients a week. And that is not a good access to care.

So I appreciate you listening to me. And I think although the data kind of speaks for itself in the report, I think what's more important is for providers like us, myself, to really give yourself and the Department an insight of what really happens out there, because we're the ones that patients will call and say, you know, "they wanted to refer me to home health but they said you couldn't take us back." This was a discharge and they liked our agency and wanted to come back. We sadly have to explain to the patients that we have as much MediCal as we can handle doing right now and unfortunately we can't re-admit you at this time. They don't want to be in the hospitals. Their families don't want them in the hospitals. But that's where they are if the agencies can't absorb them. And they can't. Not at losing half of what it costs us to deliver the service.

So again, I thank you for your time and

appreciate you listening.

HEARING OFFICER MENDOZA: Thank you, Mr. Dial.

Is there anyone else that would like to speak to the report?

MR. DE PRIEST: I would. My name is Jarrod DePriest, Vice President of Operations for Maxim Healthcare Services.

We have submitted a comment paper to the Department. I just wanted to take a second and highlight a few of the points that we made in the letter.

We're a national provider, and we have 27 licenses in certified locations in the state of California. We provide service to 6,000 consumers on a weekly basis, 1300 or so of those folks are enrolled in the EPSDT or the NIF waiver programs that are reimbursed from MediCal. Folks in those programs are at home. They've chosen to be in that environment versus a subacute type of setting. And they receive hourly services, which is somewhere between eight hours and 22 hours a day, based on their diagnosis, based on the skilled interventions that are required to keep them in the home. They breathe on a vent. They eat through a tube somewhere. They have seizure disorders. They have some sort of intense medical need that requires nurses to be in the house so they can remain there with the loved ones in the environment they

thrive in.

Some of the services talked about today have been intermittent services, and those are services that are provided up to two hours a day, several times a week to provide some sort of intervention.

One of the highest unmet needs in the state are intermittent pediatric services, and those services usually revolve around kids who are coming out of the hospital who have recently had surgery so they would need wound care at home, some sort of IV therapy at home, sometimes it's well mother visits post-birth to make sure things are going on well in the home.

And our company has -- due to the economics of the reimbursement model, our company has elected to not participate and provide any pediatric intermittent services in the state. So although we do focus our energies on the private-duty nursing aspect, the reimbursement matrix for the intermittent piece makes it unviable.

And again, from San Diego to Orange, L.A. County up through San Jose and San Francisco, there is not one provider who will consistently provide pediatric intermittent therapy or skilled nursing services.

During 2001 when there was the ten percent -- when the Department was charged with cutting the MediCal

reimbursement rates by ten percent, our company went to work with the Department to try and illustrate there is an access issue. So although the paper that we're talking about today focused on the time period between 2001 and 2005, we really believed it and sought to approve and illustrate there remains and there still is an access issue.

So we looked at claims submitted by home health providers on the behalf of beneficiaries in the quarter -- first quarter of 2008, which was prior to the one percent reduction in the MediCal rates, and then we compared those claims to first quarter of 2001. And what we saw there was with a one percent reduction in reimbursement rates, we saw a 14 percent drop in the number of home health agencies providing services for those hourly services I described earlier. So either RN, LPN, or home health aid hourly services. We saw a 14 percent reduction.

And to kind of put, you know, some framework around that, there is only -- at that time in the first quarter of Q1, the claims showed us there was only 117 individual providers. So this was based on NPI number. There is only 117 providers billing the State for -- seeking reimbursement from the State for services and those EPSDT or waiver programs.

At the same time, when we look those claims from

the first quarter of '08 and first quarter of 2011, the number of enrollees grew in those service categories from 2,895 participants in '08 to 3,224 in 2011. So we see a decrease in the number of providers actually seeking reimbursement for the services, while the number of enrollees are going up.

The California Labor and Workforce Development Agency found that in the first quarter of 2011, the hourly mean wage for RNs was $38.67. The current reimbursement rates for RN services in those waiver programs is $40.16. So the spread there is about a $1.60 and some change.

On the LVN side, the mean wage for LVNs in the State, first quarter 2011 was $25.24. And the reimbursement for LVN services in those waivers was $29.12. What that cost doesn't include is from an agency perspective the cost of actually employing a caregiver. So it's federal income tax, State income tax, State unemployment tax, workers' compensation, the general liability, mileage, and other costs that aren't -- background checks that aren't associated with the cost of employing that person.

That cost -- the soft cost is generally in the average 15 to 17 percent, depending on the time of the year. So if you add 15 percent on the low side to the hourly mean wage of 38.67, compare that to the

reimbursement rate of $40.16, that makes the service line unviable.

On the LVN side, you add 15 percent to the $25.24 compared to the reimbursement rate, there is a small window of margin there to provide that service.

The other piece that we looked at or the other side that we looked at when we were looking at this scenario back in 2011 was that in the whole state there is less than a thousand licensed beds that would accept a pediatric -- sorry -- there is less an a thousand beds that are licensed in the pediatric subacute throughout the whole state. So we actually picked up the phone and we did a survey of every pediatric license subacute facility to see how many available beds there would be at that time that would take a MediCal pediatric vent, trach, G-tube patient. And the response was alarmingly low. It was just a little more than 100 beds available at that moment in time.

Now, that was couple years ago. So to go through that same exercise today, it would be interesting to see how the data would shake out.

Just recently, there was a report released by the AARP on a study conducted in 2008. And the results were just released in 2013 that continues to show that in California spending on nursing home care per person is

three times higher than in the home community-based services programs. In California, the State spends on average $32,406 for nursing facility care versus $89,129 for home and community-based services.

This is the lowest cost highest level of care alternative. And due to the reimbursement model, it has and has continued to create an access issue. Thank you.

HEARING OFFICER MENDOZA: Thank you.

MR. ERMAN: My name is Kennith Erman. I'm the CEO for RX Staffing and Home Care. We are a licensed home health agency here in the greater Sacramento area, privately owned. My mom started the company 22 years ago. We have been licensed as a MediCal provider since -- Medicare and MediCal provider since 1996.

And before 2001 up to actually probably -- actually, probably before 2004, our MediCal percentage of revenue for our home health department was over 90 percent. It's less than ten percent currently and has been reduced -- has been reducing ever since the early thousands, you know, about 2003, 2004. Decreasing because of the constant threats to the MediCal reimbursement. And it made it just so difficult to be able to provide care -- nursing care for the hourly patients in the home, which we did quite a few of. And even more so, it was difficult or it's really impossible to provide intermittent home health

to a MediCal patient.

Currently, there is -- we've had the reimbursement the same -- actually, it's less since 2001 was the first rate increase in the last 25 years in MediCal, and it's been cut by the one percent and threatened five and ten percent cuts almost every year.

So there has not been any rate increase. And the cost for providing care has gone up exponentially. We are doing home health, so we're providing mileage. Just also for nursing wages and workers' comp and just the cost of doing business, as David Dial so aptly demonstrated with his data. You know, we have increasingly had to take a loss for any MediCal patient that we take. Our reimbursement is less than $74 per visit, and it costs me just for the nurse $95 per visit. And that's not counting any overhead for office and rent and insurance.

So we're immediately losing, you know, 35 to $40 because it probably costs us probably about $120 when you add on the rest of all of our expenses and to make something that would be a reasonable profit line, margin.

We have been taking MediCal patients. We do that as we feel it's our obligation, but it is at a loss. MediCal pays 40 to 60 percent of what a private insurance will pay. And pays really about 25 or 30 percent of what a Medicare will pay.

There is no -- much less access of care in this area. We have to negotiate with everyone that we take, making sure that it has -- we don't get reimbursed for any of our supplies when we're doing wound care. It can be extremely expensive, and many of the MediCal patients require social work and multiple disciplines on their visits. They're very difficult cases. So their acuity is a lot higher than the acuity for private and Medicare patients. Because you have hospitals and you have skilled nursing facilities more quickly discharging their MediCal patients than they are discharging any of their other kinds of patients.

I think that it's going to be critical that there is some changes if California is going to still maintain Medicaid -- as a Medicaid provider in the union. Because there is no way that home health will be an option for all of the new MediCal subscribers that will be added on by Obama Care. And they may get insurance, but it won't be a viable insurance that anyone will service.

But looking back even at the 2001 to 2005, we had -- because of the rate decrease, the one percent and the threatened decreases, we have consistently reduced the number of MediCal patients that we could service onto our patient load. Like I said, it dropped from the over 90 percent to ten percent or lower on our current census.

And any quick look at the expense of providing a nurse into a patient's home will demonstrate that it is impossible to provide nursing as an agency without subsidizing it with other providers in California.

So I corroborate the data that you heard from all of the previous speakers. It is correct that the number of providers has gone down and that the amount of possible revenue or -- actually, the expense has gone way up while the reimbursement has gone down over these past 20 years that we've been providing the service.

And I just ask that the State will finally consider what it has to do as an option for MediCal to be a viable insurance provider so that we can again provide services to these desperately needy subscribers. There are millions of providers -- I mean millions of subscribers of MediCal that are unable to get services. And it is only pushing people back into higher levels of care, which is already going to cost the State because they're billing MediCal. And the rate of what MediCal pays to a skilled nursing facility or to a hospital is much, much higher than for home health. So it's absurd to delay it another day. So that's my plea.

HEARING OFFICER MENDOZA: Thank you, Mr. Erman.

Would anyone else like to provide comment or comment on things you may have heard this morning?

MR. GRINSTEAD: Good morning. My name is Jason Grinstead.

Thank you for providing me with the opportunity to make comments on the Department's report. I'm the administrator of Care at Home, State licensed Medicare and MediCal certified home health agency located in Campbell, California. We care for clients in the San Francisco Bay Area, including MediCal clients and have done so for over 15 years.

As a member of the California Association for Health Services at Home, I've been following this case since 2007 and have attended most public hearings relating to this case since that time. I submitted a response letter to Mr. Mendoza dated April 6th, 2013, that provided my perspectives on the Department's report. I submitted an updated version of this letter for your review today. Please disregard the first version.

In summary, my analysis of the Department's report and data concludes that, first, the report's data demonstrate a 24 percent decline in utilization of home health care services by the growing MediCal population during the 2001 to 2005 period.

Second, the report's data utilizes a flawed comparison of Medicare and MediCal access by beneficiaries to home health care services. Correcting the analysis

utilizing the Department's data demonstrates a 30 percent decline in relative access to care for MediCal beneficiaries when compared with access to care for California's Medicare beneficiaries.

Third, the report concludes that there is no relation between access to care and reimbursement rates. In contrast, utilizing Medicare and MediCal rates data and comparing that to access, I conclude that the decline in Medicare beneficiary access to home health care is directly correlated with insufficient rates during 2001 to 2005 period.

In particular, in one example, on average, MediCal's rates were, at maximum, only 77 percent of the Medicare rate determined to provide sufficient access and efficiency, economy, and quality of care.

As a result, MediCal's rates did not cover the costs determined annually by Medicare through cost reports, cost surveys, and other cost related investigations to provide care of sufficient quality efficiency and economy.

Fourth, the report did not consider regional differences in costs of home health care within California that further limit MediCal beneficiary access to care, particularly those living in highly populated, high cost regions of our state. Utilizing Medicare data, in one

example, I demonstrated that the cost of care varied by 46 percent from one county to another on average during the 2001 through 2005 period. This dramatic regional variation cost further decreased MediCal beneficiary access to care.

Finally, Care at Home has been a longstanding provider of care to MediCal patients, particularly children. This has been one of the cornerstones of our community-based mission for over 15 years. Anecdotally, we can confirm what most already know and the data demonstrates. Reimbursement rates for MediCal home health services have been and are woefully inadequate to enable sufficient access to care for MediCal beneficiaries. It has been and is extremely challenging to recruit staff who can provide this care when their reimbursement rates and, thus, the compensation rates are so low.

Furthermore, unlike Medicare's rates, MediCal reimbursement rates bear no relationship to the costs of care, as evidenced by the fact that the current reimbursement rate is approximately equal to that in 1994, almost 20 years ago. As you know, the cost of almost everything in our state has risen in the past 19 years, including the increased regulatory compliance, licensing, and tax burdens imposed by the State during that time.

Home health care is a cornerstone of the cost

effective health care by keeping MediCal beneficiaries out of significantly more expensive care environments like emergency rooms and hospital wards. Ensuring access to home health care for MediCal beneficiaries through sufficient rates is an important way for the State to save health care costs.

Consequently, I respectfully request the State consider these facts and provide home health care reimbursements that are aligned with the true costs of providing home health care that has efficiency, economy, and quality of care during the period 2001 through 2005 and going forward.

To do this, I recommend the Department utilizes Medicare's annual rate setting studies as a basis for its rates. As the administrator of a community-based mission driven organization that considers caring for MediCal patients to be just as important as caring for all of our patients, I would be happy to volunteer my time to work with the Department staff to establish these rates across all home health care services and ensure that MediCal beneficiaries receive adequate access to care through adequate MediCal home health reimbursement rates.

Thank you for your time and serious consideration of this matter. I urge you to act to ensure that MediCal home health rates are increased to ensure MediCal

beneficiaries receive adequate access to care. Thank you.

HEARING OFFICER MENDOZA: Thank you, Mr. Grinstead.

MR. DIAL: I had a clarification.

Dave Dial with Pro-Care Home Health Services.

I did want to make it clear because it did come up a couple times today about the ten percent increase in the year 2000. The ten percent increase in the year 2000 was not driven by any work by the Department. That increase was through cautious efforts and other efforts to get a legislative remedy to a disastrous rate situation in that year 2000.

Now, considering that ten percent increase relative to that and all prior increases, the relative rate that was gained by the ten percent increase in 2000 was relative to what we were -- would have gotten paid and should have gotten paid in the '80s. Didn't bring us current to 2000. Didn't help a lot. It was a Band-Aid on a severe situation. And that was a legislative correction, not through any rate reviews or work by the Department in the rate reviews. I just want to make that part clear. Relatively speaking, like I say, that increase brought us up to a comparable rate not 1980s.

HEARING OFFICER MENDOZA: Thank you.

Anyone else?

Hearing no other comment, we're going to hold the oral comment period open for another 45 minutes. Please note that we're still accepting written comment through 5:00 o'clock today. You can submit those to my attention. We can send them electronically to again the address that was listed in the public notice, if you'd like. It's 2013hhacomments@dhcs.ca.gov.

MR. LEVENTHAL: The ones that he gave to you, they're accepted?

HEARING OFFICER MENDOZA: They're fine. I got those, yes.

UNIDENTIFIED SPEAKER: Can you repeat that address?

HEARING OFFICER MENDOZA: 2013hhacomments@dhcs.ca.gov. We're accepting those up until 5:00 o'clock today. So we'll take a break for 45 minutes. If no none should appear in the next 45 minutes, we'll consider the public hearing closed at noon. Thank you.

(Whereupon a recess was taken from 11:16 am to 11:56 am.)

HEARING OFFICER MENDOZA: Back on record.

We note all speakers left approximately 12:20. Sorry. All speakers left at 11:20. It is now noon. So since there are no other speakers available, we hereby

close this public hearing for public comment.

Thank you.

(Whereupon the hearing adjourned at 11:59 AM.)

CERTIFICATE OF REPORTER

I, TIFFANY C. KRAFT, a Certified Shorthand Reporter of the State of California, and Registered Professional Reporter, do hereby certify:

That I am a disinterested person herein; that the foregoing hearing was reported in shorthand by me, Tiffany C. Kraft, a Certified Shorthand Reporter of the State of California, and thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties to said hearing nor in any way interested in the outcome of said hearing.

IN WITNESS WHEREOF, I have hereunto set my hand this _____ day of _____, 20_____.

_____

TIFFANY C. KRAFT, CSR, RPR

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