Summary of Public Comments on Home Health Agency Further Rate Review 2001-2005
and Responses by Department of Health Care Services

On March 15, 2013, the Department of Health Care Services (DHCS) published a report summarizing findings of a further rate review it conducted to determine if Medi-Cal beneficiaries had sufficient access to home health agency (HHA) services during 2001-2005 consistent with 42 United States Code section 1396a(a)(30)(A).[1] On March 15, 2013, DHCS published notice of the further rate review in the California Regulatory Notice Register. DHCS also published the further rate review on the Medi-Cal website. Persons could submit written comments up until close of business April 15, 2013. Also, DHCS held a public hearing on April 15, 2013, at which persons could present comments.

Persons Submitting Comments

The following persons submitted comments on the further rate review. Some comments were only submitted at the public hearing, some were only submitted in writing and some were submitted both in writing and at the public hearing.

Henry Zaretsky: Submitted comments at the public hearing and written comments.

David Dial: Submitted comments at the public hearing and written comments.

Jason Grinstead: Submitted comments at the public hearing and written comments.

Robert Leventhal: Submitted comments only at the public hearing.

Jarrod DePriest: Submitted comments at the public hearing and written comments.

Ken Erman: Submitted comments only at the public hearing.

Catherine Johnston: Submitted only written comments.

[1] Any further references to section 1396a (a) (30) will be to that section of title 42 of the United States Code.

Summary of Public Comments and DHCS Responses

Comments by Henry W. Zaretsky (Henry W. Zaretsky and Associates)

Comment 1

Mr. Zaretsky presented the following general conclusions.

1) DHCS's findings that there was sufficient access from 2001-2005 are inconsistent with its own data.

2) DHCS's data shows worsening access during 2001-2005.

3) DHCS's analysis failed to address the correct issue, namely the federal statutory requirement that access for Medi-Cal beneficiaries be at least as good as that available to the general population.

Response 1

DHCS disagrees with Mr. Zaretsky's conclusions. He provides more specific comments and data in an effort to support his general conclusions. Following is a summary of his specific comments, the data he presented and DHCS's responses.

Comment 2

Mr. Zaretsky contends that in determining whether Medi-Cal beneficiaries had sufficient access to services under section 1396a(a)(30), DHCS failed to determine whether access was as good as that available to the general population.

Response 2

DHCS evaluated how Medi-Cal beneficiary access compared to that of the general population by comparing the access Medi-Cal beneficiaries had to HHA providers to that of Medicare beneficiaries.

The Medicare program is the largest public or private insurance program that pays for HHA services received by persons in the general population. Thus, in evaluating access in the June 2008 rate review, DHCS compared data on HHA participation in Medi-Cal to HHA participation in the Medicare program.

Table 7 of the June 2008 study showed that there was growth in the number of HHA providers participating in both Medi-Cal and Medicare during 2001-2005. However, in reviewing these findings, the Court of Appeal in *California Association for Health*

Services at Home v. *State Department of Health Care Services* (2012) 204 Cal.App.4th 676, stated:

> "[W]hile the Department touts the fact that the average number of Medi-Cal home health agency service providers grew seven percent during the relevant time period, plaintiffs correctly note that according to the Department's own data the average number Medicare home health service providers grew 26 percent during the same period, and the difference between the number of home health agencies that accept Medicare and the lower number that accepted Medi-Cal more than doubled during the same time period. The plaintiffs persuasively argue that the growing discrepancy 'would cause any reasonable person to question whether Medi-Cal beneficiaries have as much access to home health care services as the general population.'" (*Id. at ps. 688-689.)*

The Court of Appeal seemed to agree that a comparison between provider participation in Medi-Cal and Medicare was an appropriate way to assess whether Medi-Cal beneficiaries access to HHA services was as good as that available to the general population.

Therefore, in the further rate review, DHCS compared HHA participation in Medi-Cal and Medicare in relationship to the number of people in each program that are most likely to need HHA services. That would include persons who are aged (65 years of age or older) or disabled (see Further Rate Review at pages 8-10, and Table 2). All persons eligible for Medicare are aged or disabled. Thus, in Table 2 of the further rate review, DHCS included data on the number of all persons enrolled in the Medicare program in California from 2001-2005 and the number of Medi-Cal eligible persons who were aged, blind, or disabled for the same timeframe.

Table 2 of the further rate review shows that for all five years, there were many more Medicare eligible aged and disabled persons for each Medicare participating HHA than there were Medi-Cal eligible aged, blind, and disabled persons for each Medi-Cal participating HHA. Thus the Medicare program had a much greater number of eligible persons of the age and physical condition most likely to need HHA services. This helps explain why there were more HHAs participating in Medicare than Medi-Cal and the greater growth in provider participation in Medicare during 2001-2005.

For example, in 2005, for each HHA participating in Medicare, there were 6,594 Medicare enrollees in California, and for each HHA participating in Medi-Cal there were only 3,681 Medi-Cal eligible persons who were aged, disabled, or blind.

Table 2 of the further rate review shows that for all five years, the number of Medi-Cal participating HHAs for each Medi-Cal eligible aged, blind, or disable person was much greater than the number of Medicare participating HHAs for each California Medicare

beneficiary. Based on this data, the Department concluded that during 2001-2005, Medi-Cal beneficiaries had access to HHA services that was at least as good as that available to Medicare beneficiaries. Therefore, DHCS concluded that Medi-Cal beneficiaries had access to HHA services at least as good as that available to the general population.

Comment 3

Mr. Zaretsky further contends that DHCS should have looked at more specific data with respect to length of time from request for service to provision of service and difficulty in placing patients and unmet needs. He says DHCS had access to such data which could be supplemented with surveys based on samples of providers. He suggests that DHCS could have done a survey of providers to collect this sort of data.

Response 3

Contrary to what Mr. Zaretsky states, DHCS does not maintain the sort of detailed alternative data he suggests. For example, he suggests that DHCS should have evaluated the length of time between "request for service" and getting services. It is not clear what he means by "request" for service (e.g., a beneficiary asking a doctor about the need for services, a doctor referring a patient to an HHA, an HHA submitting a treatment authorization request (TAR) to DHCS). DHCS does not collect or maintain data on the length of time it takes for Medi-Cal beneficiaries to obtain any specific Medi-Cal covered services from the date they see a doctor or other health care professional about the possible need for such services. Similarly, DHCS does not collect or maintain data regarding the time it takes for Medi-Cal beneficiaries to obtain HHA services from date of referral.

Table 8 of the June 2008 study showed a steady increase in the number of TARs that HHAs submitted to Medi-Cal for services during 2001-2005, as well as the number of TARs that DHCS approved. Moreover, the average processing time steadily decreased from 8.6 days in 2001 to 2 days in 2005. As noted in the June 2008 study, TAR processing "is not inhibiting Medi-Cal beneficiary access to home health services." (Page 15 of June 2008 study).

With respect to the suggestion that DHCS should have looked at "difficulty in placing patients and unmet needs," DHCS does not collect or maintain such data. DHCS maintains statistical data on the number of TARs processed, claims paid, beneficiaries receiving services, and dollars spent for the services.

The suggestion that DHCS should have conducted a survey of HHAs for the period of 2001-2005 was not feasible within the time DHCS had to complete the further rate review. This would have involved significant time to prepare a survey instrument, mailing it out, time for surveyed persons to respond, time to tabulate the results, and time for analyzing and summarizing the data. In addition, this type of survey would most likely be more opinion-based rather than data-centered, and not result in obtaining objective and measurable data from a time period 8-12 years in the past.

Moreover, DHCS does not believe that providers generally maintain data, particularly so far in the past, on how long it took each person it served to get HHA services from the date a physician or other health care professional was consulted and recommended such services, particularly with respect to beneficiaries they did not provide services to. Also, DHCS does not believe HHAs generally maintain data on beneficiaries that needed and desired HHA services who were unable to obtain an HHA provider. HHAs would typically maintain data on patients they served (i.e., those that were able to obtain services from an HHA) and not those they didn't serve. Thus, any information HHAs might be able to offer on these issues is most likely going to be anecdotal and, perhaps, somewhat subjective.

In summary, instead of conducting a survey, DHCS relied on data it maintained from the period 2001-2005.

Comment 4

Mr. Zaretsky contends that a comparison of data in Table 1 of the further rate review for 2001-2005 to data for 1992-1997 contained in the 1998 access study, shows that access worsened between 1997 and 2001.

Response 4

Based on a comparison between the data in Table 1 of the further rate review and the data for 1992-1997 included in the 1998 access study, access was much better in 2001 than in 1997 (the last year considered in the 1998 study), and significantly better than 1992-1996. The amount of money that Medi-Cal pays to a provider is a function of services rendered times the rate of reimbursement for each service. Thus, the amount of Medi-Cal expenditures for HHA services rendered to Medi-Cal beneficiaries is a good measure of the volume of services provided. Based on the 10% rate increase that became effective August 1, 2000, the rates paid for each HHA service during 2001-2005 were 10% higher than the rates paid for each service in 1992-1997. That means only 10% of the growth in Medi-Cal expenditures in the 2001-2005 period is attributable

to higher rates and 90% of the growth is due to HHAs providing an increasing volume of services.

In 1997, Medi-Cal reimbursed HHAs $61,922,359. In 2001, Medi-Cal reimbursed HHAs $147,014.00, which is approximately two and a half times greater than in 1997. Additionally, Medi-Cal reimbursement per user was significantly higher in 2001 than in 1997. For example, the 1998 study showed that in 1997, Medi-Cal reimbursed HHAs an average of $551 monthly for each user, which was up from $252 in 1992. In 2001, Medi-Cal reimbursed HHAs a total of $1,818 monthly for each user. If $1,818 is reduced by 10% to reflect the August 2000 10% rate increase, the adjusted amount is $1,636 monthly for each user. That is triple the amount of expenditures per user in 1997 and would be based solely on an increased volume of services provided per user in 2001 compared to 1997. Moreover, the number of "users" as a percentage of the Medi-Cal fee-for-service eligible population in 2001 was comparable to 1997. In summary, DHCS determined that access to HHA services in 2001 was better than in 1997, based on number of users, an increased volume of services being provided to each user, and the availability of alternative providers that some beneficiaries may have preferred over HHAs (e.g., ADHCs or personal care service providers).

Comment 5

Mr. Zaretsky contends that the data on "units" contained in Table 1 of the further rate review represent "claims" for reimbursement and are an arbitrary measure of volume of services being provided. He says a "claim" is a bill that a provider submits to Medi-Cal for reimbursement of services provided and that increasing claims is a reflection of the fact that providers are submitting claims more frequently to get paid more quickly instead of bundling multiple services rendered to a beneficiary in a single claim. He further provides data in his own Table 1 showing that based on the volume of Medi-Cal expenditures and total units in Table 1 of the further rate review, expenditures per claim are going down.

Response 5

Mr. Zaretsky's contention that HHAs were submitting claims more frequently with fewer services included on each claim, and submitting fewer claims with multiple services, would explain why Medi-Cal expenditures per claim were going down during this period. The fact that providers decided to take advantage of the Medi-Cal claims processing system by submitting more claims in order to receive reimbursement more quickly does not illustrate that there was an access problem for beneficiaries during 2001-2005. More significant is the fact that HHAs were providing an increasing volume of services

to each beneficiary served, as measured by growing Medi-Cal expenditures, as explained in DHCS's response to Mr. Zaretsky's Comment 6.

Comment 6

Zaretsky presents his own Table 2, which shows that based on the number of Medi-Cal fee-for-service eligible persons and the annual Medi-Cal expenditures paid to HHAs for each year, the amount of Medi-Cal expenditures per Medi-Cal fee-for-service eligible beneficiary gradually went down from $54.33 in 2001 to $49.23 in 2005.

Response 6

Zaretsky's mathematical calculations are correct. However, the amount of Medi-Cal expenditures per Medi-Cal fee-for-service eligible person has little relevance as a measure of access. That is because a majority of the fee-for-service eligible population is not aged, blind, or disabled, but rather in family aid eligibility categories that are much less likely to need HHA services.

If the volume of expenditures per each fee-for-service eligible beneficiary has relevance, the amount of Medi-Cal expenditures per fee-for-service eligible beneficiary in each year from 2001-2005 far exceeded the Medi-Cal expenditures per fee-for-service eligible beneficiary in 1997, which yielded the highest expenditure per beneficiary amount in the 1998 access study. Specifically, according to the earlier study, Medi-Cal expenditures to HHAs in 1997 were $16.95 per fee-for-service eligible beneficiary. For each year of the 2001-2005 period, Medi-Cal expenditures to HHAs per fee-for-service eligible beneficiary were three times the amount expended in 1997.

More importantly, the best measure of the extent to which HHAs are willing to provide an increasing volume of services to their Medi-Cal eligible patients, is to look at how much Medi-Cal spends for each "user" of services. Increasing Medi-Cal expenditures from 2001-2005 reflect an increasing volume of services provided because expenditures are based on the volume of services being provided times the rate for each service and the rates paid for each year during the 2001-2005 period were the same.

Average monthly Medi-Cal expenditures to HHAs per Medi-Cal beneficiary receiving HHA services during 2001-2005 were as follows:

2001 - $1,818

2002 - $1,921

2003 - $1,779

2004 - $2,266

2005 - $2,590

Table 1 of the further rate review shows that there were more “users” in 2004 than in 2001 and 2002, and that based on expenditures, HHAs provided more services to each user in 2004 than in 2001 and 2002.

Comment 7

Zaretsky contends that because the number of average monthly users as a percentage of the Medi-Cal fee-for-service eligible population dropped in 2005 to a level below that in 2001, this illustrates declining access over the period 2001-2005. He further contends that because the percentage of users relative to the fee-for-service eligible population steadily increased from 1992-1997, access in 2001-2005 was not as good as it was during the period analyzed in the 1998 access study.

Response 7

Zaretsky focuses on the drop in users in a single year to contend that access over the five-year period was declining. If one were to focus on variations in the number of users from one year to the next as Zaretsky does, one would have to agree that access was far better in 2003 and 2004 than it was in 2001 and 2002 because the average monthly HHA users in both 2003 and 2004 were much higher than in both 2001 and 2002 when HHAs were providing an increasing volume of services to these users. It is not possible to provide an exact explanation for why the average monthly users vary from one year to the next. However, it is not accurate to say that the number of users was on a steady decline over the period 2001-2005. The number of users peaked in 2003, and in 2004 was still higher than in 2001 and 2002.

A more accurate description would be that the number of average monthly users varied over the period 2001-2005 both in absolute numbers and as a percentage of the fee-for-service eligible population.

DHCS has previously responded to Zaretsky’s comment that access in 2001 was not as good as it was in 1997 by pointing out that the number of users relative to the fee-for-service eligible population was comparable in the two years and the volume of services provided to each user (as measured by Medi-Cal expenditures) was far greater in 2001 than in 1997 (see DHCS response to Zaretsky Comment 4).

When compared to the percentages of users relative to the fee-for-service eligible population, the data for 2001-2005 overall compares favorably to the data for 1992-1997 in the 1998 access study. For example, the percentages for 1992, 1994, and 1996 respectively were .13%, .16%, and .22%.

Moreover, taking into account the variation of users during the 2001-2004 period, DHCS does not believe that the only reasonable explanation for the drop in users during 2005 was simply because HHAs were suddenly less willing to provide services to Medi-Cal beneficiaries any more than it would believe that the only reasonable explanation for there being more users in 2003 and 2004 as compared to 2001 and 2002 was due to the fact that HHAs were more willing to provide the necessary services. Table 2 of the further rate review shows that there were more HHA providers rendering services to Medi-Cal beneficiaries in 2005 than in 2004 and 2001.

A reasonable explanation for there being fewer "users" of HHA services in 2005 was that policy changes implemented over previous years (e.g., see discussion of these changes at pages 6-8 of the further rate review) were starting to have an impact on the number of beneficiaries choosing to receive HHA services. In other words, beneficiaries that might otherwise receive HHA services had other provider alternatives that could meet their needs. Moreover, for each "user" that continued to receive HHA services, HHAs provided an increasing volume of services, as measured by Medi-Cal expenditures for each user (see response to Zaretsky Comment 6).

Comment 8

Mr. Zaretsky contends that the explanations at pages 6-8 of the further rate review for what he contends was "worsening" access from 2001-2005, were "speculative" and "anecdotal."

Response 8

First, as stated in response to previous Zaretsky comments, the data in Table 1 does not show that access got worse from 2001-2005. There were increasing Medi-Cal expenditures during the entire period, which represents increased volume of services being provided. The amount of Medi-Cal expenditures, and thus, the volume of services provided, for each beneficiary receiving HHA services went up during 2001-2005. There was no specific consistent trend up or down in the number of users. The number of users for 2003 and 2004 was much higher than in 2001-2002. There was a drop off in users in 2005 comparable to 2002. As stated previously, a single year change in data is insufficient to conclude that there was suddenly an access problem in 2005, when the data clearly shows no access problem in the prior 4 years. DHCS

determined that the drop in users in 2005 is due to the fact that beneficiaries were instead choosing to receive necessary services from alternative providers that met their needs. The policy changes discussed on pages 6-8 of the rate review reflect the growth of these alternative provider types that impacted the number of beneficiaries obtaining services from HHAs.

The 1998 access study illustrates how a change in Medi-Cal policy without any change in reimbursement rates can impact HHA services. That study noted that the reason Medi-Cal expenditures for HHA services doubled between 1995 and 1997 was because of a policy change authorizing home health care in the Medi-Cal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program to cover private duty and shift care for disabled minors in the home (page 29 of June 1998 access Study).

The policy changes discussed on pages 6-8 of the further rate review were not anecdotal or speculative. Rather, there were documented policy changes which resulted in beneficiaries having more alternative provider types that met their needs.

For example, there was a statutory change to allow “for profit” adult day health centers (ADHCs) to provide services. In the period after 1998, there was a three-fold increase in the number of ADHCs participating in the Medi-Cal program. This was not anecdotal or speculative. There were 230 ADHCs participating in Medi-Cal in 2001 and a total of 338 by 2005 (page 6 of further rate review).

Another change that was first implemented in 2000 was that Medi-Cal began to cover pediatric day health care for disabled children, which could have become a preferred alternative to in-home nursing care for some families (see page 6 of further rate review).

There were also policy changes under the EPSDT program for children and under the Medi-Cal Home and Community Based Services (HCBS) program that provided increased opportunities for individual nurse practitioners, instead of HHAs, to provide necessary professional nursing services in the home. It is very possible that some of the reduction in HHA users may have been caused by an increase in beneficiaries receiving in-home nursing from individual nurse practitioners (see pages 6-7 of further rate review concerning these policy changes).

DHCS also believes that an increasing number of elderly beneficiaries needing in-home assistance may have opted for personal care services provided by a family member instead of receiving in-home nursing services from an HHA or an individual nurse practitioner. This is another factor that could have reasonably contributed to a reduction in beneficiaries using HHA services (see pages 7-8 of further rate review).

Medi-Cal covers personal care services in accordance with Welfare and Institutions Code section 14132.95. These are in-home personal care services described in

subdivision (d)(1) of that statute. The program is administered by the California Department of Social Services (CDSS), but is considered a Medi-Cal covered service when provided to Medi-Cal eligible beneficiaries. Almost all persons receiving these services are Medi-Cal eligible and aged, blind, or disabled. The average monthly caseload of persons receiving these services has steadily increased through the years, including an increase from 250,000 in July 2001 to approximately 350,000 in July 2005 (see http://www.cdss.ca.gov/cdssweb/entres/localassistanceest/May13/Caseload.pdf at p.13). The average monthly case load increased by over 15,000 between state fiscal year 2003-2004 and 2004-2005 and by another 19,000 between state fiscal year 2004-2005 and 2005-2006 (*Id.* at p. 14). DHCS believes that some of the drop in HHA users in 2005 is related to an increasing number of Medi-Cal beneficiaries who were receiving personal care services during this time.

In summary, there were reasonable explanations for a reduction in HHA users in 2005 unrelated to any access problem. If all the relevant data had been on a constant and steady decline, the drop in users in 2005 could suggest a problem. But the number of users had increased to levels in 2003 and 2004 well above the levels in 2001 and 2002, even though the reimbursement rates in 2003 and 2004 were the same as in 2001 and 2002. Moreover, the number of HHAs providing services to Medi-Cal beneficiaries increased in 2005 over 2004. HHAs provided an increasing volume of services to beneficiaries they were serving over the period 2001-2005 as measured by growing Medi-Cal expenditures. DHCS believes the fact that HHAs were providing an increasing volume of services to the beneficiaries they were serving supports the proposition that the drop in users in 2005 was most likely related to beneficiaries deciding to receive necessary services from alternative available providers. Finally, even if one were to alternatively conclude that access for Medi-Cal beneficiaries worsened in 2005, section 1396a(a)(30)(A) simply requires that Medi-Cal beneficiaries had access as good as that available to the general population, and DHCS believes that Table 2 of the further rate review supports the fact that they did for the entire period 2001-2005.

Comment 9

Mr. Zaretsky states that if Medi-Cal beneficiaries are forced to obtain services from an alternative provider such as an ADHC or pediatric day care provider because of the inability to find an HHA willing to provide services that this indicates an access problem.

Response 9

DHCS agrees that if beneficiaries needing and wanting services provided by an HHA were unable to find an HHA willing to provide such services, that would present an

access issue. But there is no evidence that was happening during 2001-2005. As previously stated, DHCS believes many Medi-Cal beneficiaries who might qualify for receiving the in-home nursing services from an HHA made a choice to receive services from an alternative provider that met their specific needs (e.g., individual nurse practitioner, personal care service provider, ADHCs, pediatric day care).

Comment 10

Mr. Zaretsky says there is no evidence of any overlap between Medi-Cal beneficiaries that might need ADHC services and those that might need HHA services.

Response 10

On the contrary, ADHCs provided skilled nursing services and therapy services to aged and disabled persons, of the same type that may alternatively be provided in the home (Title 22, California Code of Regulations(CCR), § 54309-54323). ADHCs were to be open to beneficiaries a minimum of 6 hours per day to a maximum of 12 hours per day, at least 5 days per week (Title 22, CCR § 54221). It is reasonable that some recipients who would have qualified for nursing or therapy services provided by an HHA in their home could have chosen to instead receive such services at an ADHC. For example, some beneficiaries and their families may have preferred the ADHC option because of the other services that ADHCs rendered (e.g., transportation, nutrition, and medical social), as well as possible psychological benefits of spending time in a group situation instead of staying home. Just as HHA services are designed to enable beneficiaries to avoid having to receive services in a nursing facility, this was also a major purpose of ADHCs (Title 22, CCR § 54209).

Comment 11

Mr. Zaretsky points out that under the HCBS waiver program, there is a cap on how much money may be spent on each beneficiary in this waiver program that is tied to how much would be spent by the Medi-Cal program if the beneficiary instead received services in an institutional setting such as a skilled nursing facility. He further states that there was an increase in Medi-Cal payments for skilled nursing facility services from 2001-2005, which would have increased the amount of money available for spending in the HCBS program. Therefore, Zaretsky claims that there should have been a constant increase in HHA users during this period.

Response 11

First, there was a significant increase in HHA users in 2003 and 2004 compared to 2001 and 2002, and a drop in 2005 to levels comparable to 2002. As noted previously, there was no consistent trend up or down in users, and DHCS believes the drop in users in 2005 was related to the availability of alternative providers that beneficiaries preferred to HHAs. Although the cap on Medi-Cal spending for HCBS waiver services during 2001-2005 may have increased, it does not mean that beneficiaries would have had to receive services from an HHA. As explained at pages 6-8 of the further rate review, DHCS believes that some HCBS waiver beneficiaries may have chosen to receive services from an individual nurse practitioner or personal care service provider, which would have eliminated the need for HHA services.

Comment 12

Mr. Zaretsky says DHCS's explanation of Table 2 of the further rate review is that the number of providers signed up as Medi-Cal participants is indicative of access for the purpose of comparing to access for Medicare beneficiaries. He points out that the mere fact that a provider is signed up to participate in Medi-Cal does not mean the provider is under any obligation to provide any services to a Medi-Cal beneficiary and that becoming a Medi-Cal provider requires little effort.

Response 12

The number of HHAs identified for each year of 2001-2005 in table 2 of the further rate review are not just providers that signed up to be providers. Rather, table 2 shows the number of HHAs that submitted at least one claim to Medi-Cal for services provided during each calendar year (footnote 2, page 9 of further rate review). There were 419 such HHAs in 2001 and 449 in 2005.

Comment 13

Mr. Zaretsky presents data in Table 3 of page 7 of his written comments, showing the number of HHAs receiving either less than $600 in Medi-Cal expenditures or more than $600 in Medi-Cal expenditures for the years 2001-2004. Mr. Zaretsky obtained this data from a publically available document entitled the "California Medical Assistance Program: Annual Statistical Report, Calendar Years 2001-2004". This particular report was not available for 2005. Mr. Zaretsky presents this data in an effort to show that

HHAs participating in Medi-Cal were providing a smaller volume of services, as measured by Medi-Cal expenditures.

Response 13

DHCS does not believe the limited data cited by Mr. Zaretsky supports this proposition. Other data contained in the same statistical report for 2001-2004 showed that the number of HHAs providing the highest volume of services, as measured by Medi-Cal payments received, either increased or remained steady, as follows:

Number of HHAs receiving Medi-Cal payments within Various Ranges

	Under $10K	$10K-$49K	$50K-$99K	$100K-$999K	$1 million plus
2001	129	108	50	108	67
2002	129	108	55	104	68
2003	123	85	56	106	72
2004	138	79	46	103	69

This data illustrates that there was no trend of an increase in the number of HHAs providing a smaller volume of services or a decrease in the number of HHAs providing a larger volume of services. As noted previously, HHAs were providing an increasing volume of services to the beneficiaries they served during the period 2001-2005, as measured by Medi-Cal expenditures (see response to Zaretsky Comment 6). Moreover, as indicated in table 2 of the further rate review, the year 2004 had the lowest number of HHAs billing Medi-Cal for services rendered during that year. The number of such HHAs increased by 53 between 2004 and 2005 (see Table 2, further rate review). Thus, if DHCS had continued doing the statistical report that Mr. Zaretsky relied on into 2005, the number of providers in the various payment categories above would likely have gone up compared to 2004.

It should be noted that the number of HHAs in the DHCS statistical report for 2001-2004 that Mr. Zaretsky relied on do not match up exactly with the number of HHAs listed for each year according to Table 2 of the further rate review. DHCS believes the difference is because the statistical report appears to have been based on the number of providers paid specific amounts in a particular year, whereas Table 2 of the further rate review is based on the number of providers that submitted Medi-Cal claims for services rendered during a particular year.

Comment 14

Mr. Zaretsky presents a table 4 on page 8 of his written comments, in which he uses the data contained in Table 2 of the further rate review to evaluate the change in the number of HHAs participating in Medi-Cal and Medicare, and the number of Medicare eligible persons and Medi-Cal eligible aged, blind, and disabled persons between 2001 and 2005. Based on this data, he contends that access got better for Medicare beneficiaries during this period than for Medi-Cal beneficiaries.

Response 14

His calculation that the number of HHAs participating in Medi-Cal and Medicare increased by 7.2% and 26.4% between 2001 and 2005 is accurate and are statistics the Court of Appeal noted in its March 2012 decision. His calculation of an increase of 6.4% in the number of Medicare eligible persons in California between 2001 and 2005 and a greater increase of 16.7% in the number of Medi-Cal eligible aged, blind, and disabled persons in California between 2001 and 2005 is also correct. However, all this reveals is that the gap between the better access that Medi-Cal beneficiaries had compared to Medicare beneficiaries was reduced between 2001 and 2005. The bottom line, as illustrated by Table 2 of the further rate review, is that for each year 2001-2005, Medi-Cal beneficiaries continued to have better access to HHA services than Medicare beneficiaries, as measured by the number of HHAs participating in each program, and by the number of beneficiaries in each program most likely to need HHA services.

Comment 15

Mr. Zaretsky presents table 5 on page 10 of his written comments containing data he obtained for 2005 from the Office of Statewide Health Planning and Development (OSHPD), Annual Utilization Report of Home Health Agencies. This shows that in 2005, there was a higher percentage of HHAs participating in Medicare providing at least 60 Medicare visits than the percentage of HHAs participating in Medi-Cal providing at least 60 Medi-Cal visits. The table also shows that in 2005, Medicare participating HHAs provided a higher average of Medicare covered visits than Medi-Cal participating HHAs provided Medi-Cal covered visits.

Response 15

First, HHAs participating in Medicare are likely to provide more Medicare covered visits because there are a larger number of Medicare beneficiaries than Medi-Cal eligible aged, blind, and disabled beneficiaries. Consequently, there are fewer HHAs participating in Medicare than in Medi-Cal relative to the persons eligible in each

program most likely to need HHA services. Therefore, it is reasonable on that basis alone that HHAs might provide a higher number of Medicare covered visits than Medi-Cal covered visits.

Additionally, the Medi-Cal program is the "payer of last resort" for Medi-Cal covered services (Welfare and Institutions Code sections 14124.90 and 14124.795.) Therefore, when a Medi-Cal eligible beneficiary needs a particular type of health care service, payments made by other available public or private insurance sources must be exhausted prior to Medi-Cal paying for the services. Currently, approximately 62% of Medi-Cal aged, blind, and disabled persons are also eligible for Medicare coverage. DHCS does not have data from the period 2001-2005 as to the percentage of such persons that would have also been eligible for Medicare coverage, but believes the percentage would have been similarly high as it is today. When such dual eligible persons need HHA services, Medi-Cal does not cover the services until all Medicare coverage has been exhausted. In other words, many Medi-Cal eligible beneficiaries that may need HHA services usually obtain coverage of such services in the Medicare program. The fact that Medi-Cal is the payer of last resort and would not provide reimbursement for HHA services until Medicare payment coverage is exhausted is another explanation for why HHAs provide a higher average number of Medicare covered visits than Medi-Cal covered visits.

Moreover, the OSHPD data that Mr. Zaretsky relied on reported HHA visits under either Medicare or Medi-Cal according to which program was the "primary source of payment". Thus, many of the visits reported as Medicare visits were likely provided to Medi-Cal eligible beneficiaries, but for which Medicare was the primary source of payment because Medi-Cal is the payer of last resort.

Comment 16

Mr. Zaretsky says that because he feels that the further rate review shows worsening access to HHA services for Medi-Cal beneficiaries during 2001-2005 and that they had access at least comparable to the general population, it is reasonable that DHCS should investigate the cause of the problem. Therefore, he believes it is relevant to review how Medi-Cal rates during 2001-2005 compared to provider costs.

Response 16

For the reasons set forth in response to Mr. Zaretsky's various comments, DHCS believes that the further rate review shows that Medi-Cal beneficiaries did have sufficient access to HHA services during 2001-2005 consistent with federal Medicaid law and disagrees with his assessment that access was getting worse during this

period. Therefore, DHCS does not believe there was an access problem during this period that necessitated resolution. The rates paid during this period were sufficient so that Medi-Cal beneficiaries had access required by federal law. It is not necessary or required for DHCS to evaluate the cause of a problem that did not exist in 2001-2005 by evaluating how rates compared to provider costs.

Comments by David G. Dial (PRO-CARE Home Health Services)

Comment 1

Mr. Dial states that his agency opened in 1995 and did tens of thousands of Medi-Cal home health visits during the first years in business and likely provided more home health services to the Medi-Cal population than did any other free standing, privately owned agency in the greater Sacramento area. He stated "we soon realized that with inadequate reimbursement rates" his agency could not remain in business much longer if it did not change the business model and focus on Medicare and private insurance.

Response 1

Mr. Dial does not specify exactly when his agency began to focus on Medicare and private insurance and the fact that his particular agency changed its business model at some point to focus more on Medicare and private insurance doesn't refute the statistical data contained in the further rate review showing that beneficiaries had access to HHA services during the period 2001-2005 to the extent required by the federal law.

Comment 2

As set forth in pages 23-29 of the hearing transcript, Mr. Dial spent some time discussing the beginning years of his HHA in the early 1990s, and how it focused initially on Medi-Cal patients, primarily medically fragile children in continuous care programs. Subsequently, in order to disburse the cost of business, it started taking intermittent home health visits. He discusses how his agency couldn't keep up with the demand of discharge planners referring Medi-Cal patients. He says that his HHA, during the first few years, was doing tens of thousands of Medi-Cal visits annually and had five dedicated Medi-Cal case managers assigned to his agency. "We were doing a tremendous amount of volume." But he says as costs continued to rise, it became more difficult to hire nurses, but his agency continued to do tens of thousands of visits annually. At some point, he said it was necessary to change the business model and provide fewer services to Medi-Cal patients and focus more on Medicare and private

pay patients. He said his HHA eventually cut its Medi-Cal patient load to about a third. He says he knows the Medi-Cal patients his HHA was providing services to were not being absorbed by other providers.

Response 2

DHCS appreciates these comments, but it is difficult to determine what time period Mr. Dial is referring to. It not clear if Mr. Dial's HHA changed its business model before the 2001-2005 period covered by the further rate review or after that period. Even if it was before the 2001-2005 period, the further rate review shows that over 2001-2005, provider participation increased and HHAs were providing an increasing volume of services to each beneficiary they served. Mr. Dial offers no evidence in support of his contention that Medi-Cal patients that his HHA didn't provide services to were unable to obtain necessary services from another HHA or alternative provider type.

Comment 3

Mr. Dial says the information in the further rate review fails to address access and is misleading in providing information that is irrelevant to the issue of access. Moreover, he says the data actually demonstrates there was an access problem.

Response 3

Mr. Dial does not provide any specific information to support his contentions regarding the further rate review. Therefore, DHCS disagrees with his contentions about the further rate review. His comments are similar to some submitted by Henry Zaretsky, which were supported with specific data. Thus, in response to Mr. Dial, DHCS refers to its responses to the Zaretsky comments 2, 3, 6, 7, 8, 9, 10, 11, 13, 14, and 15.

Comment 4

Mr. Dial makes essentially the same assertion that Henry Zaretsky made that the reason claims increased during 2001-2005 was that providers were submitting claims more frequently and not bundling as many services into a single claim. He says that because of inadequate reimbursement, many HHAs billed more frequently to get reimbursed as quickly as possible. He notes that to the credit of the Medi-Cal claims processing system, the payment turn around by the Medi-Cal program was faster than that for most payers.

Response 4

DHCS is pleased that Mr. Dial appreciates that the Medi-Cal claims processing system processed reimbursement claims quickly during this period. In further response, DHCS refers to its response to Zaretsky comment 5.

Comment 5

Mr. Dial says that the data in Table 2 of the further rate review showing an increase in the number of Medicare and Medi-Cal providers during 2001-2005 is misleading because when an agency applies to be a Medicare provider, it will simply check a box to show that it will also participate in Medi-Cal.

Response 5

DHCS does not understand the point of this comment. The data on the number of HHAs participating in Medi-Cal for each year in Table 2 of the further rate review is based on the actual number of HHAs that submitted claims for reimbursement of services provided to Medi-Cal beneficiaries during each year. The number of HHAs in Table 2 is not based on a count of the number of HHAs that merely checked a box on an application to be a Medi-Cal provider, as Mr. Dial suggests.

Comment 6

Mr. Dial says that a home health agency could not remain in business providing more than a small amount of Medi-Cal home health services and the reimbursement simply does not come close to covering the actual cost of delivering the service.

Response 6

This comment appears to be directed to current Medi-Cal reimbursement for HHA services as opposed to the adequacy of reimbursement during the period covered by the further rate review. But, to the extent that Mr. Dial may be referring to the period 2001-2005, there were many HHAs that provided a very large volume of Medi-Cal covered home health services, as measured by the increasing amount of Medi-Cal expenditures in total for each year. Moreover, several HHAs individually were paid a large amount of money by Medi-Cal, which would be based on providing a large volume of services to Medi-Cal beneficiaries (see DHCS response to Henry Zaretsky Comment 13, showing that at least 67 HHAs received more than $1 million annually from Medi-Cal).

Comment 7

Mr. Dial says that Table 2 of the further rate review contradicts the assertion that access was fine because it shows at least a 30% decline in access to Medi-Cal beneficiaries compared to Medicare beneficiaries.

Response 7

It is not clear what the basis is for Mr. Dial's assertion about a 30% decline (i.e., how he arrived at that statistic). It appears though that he is echoing Mr. Zaretsky's comment 14 that according to the data in table 2 of the further rate review, the gap between the better access for Medi-Cal beneficiaries and the access for Medicare beneficiaries was reduced during the period 2001-2005. As explained in DHCS's response to Mr. Zaretsky's comment 14, Medi-Cal beneficiaries continued to have better access than Medicare beneficiaries.

Comment 8

Mr. Dial says his HHA, as with many, "are able to accept only a modest amount of Medi-Cal home health referrals." He says his HHA does this to help the Medi-Cal population (at least in some small way) and discharge planners in the hope they will refer Medicare and private pay patients.

Response 8

This comment appears to relate to the current situation and does not appear to be focused on whether Medi-Cal beneficiaries had sufficient access during 2001-2005.

Comment 9

Mr. Dial says that common sense dictates that less than a $75 rate for a Medi-Cal home health visit is a money loser for any HHA, in relationship to what Medicare pays and the cost of the service.

Response 9

This comment appears to relate to the current situation and does not appear to be focused on whether Medi-Cal beneficiaries had sufficient access during 2001-2005.

Comment 10

Mr. Dial says the rates that managed care plans pay are also inadequate.

Response 10

The subject litigation is concerned with the rates that DHCS paid HHAs in the Medi-Cal fee-for-service system, not the rates that managed care plans pay to HHAs (see pages 2-3 of further rate review). Thus, his comment is not relevant to the issue of whether Medi-Cal beneficiaries in the Medi-Cal fee-for-service system had sufficient access to HHA services during 2001-2005.

Comment 11

Mr. Dial says that his HHA has received tens of thousands of referrals over the years by discharge planners trying to place Medi-Cal patients and that his HHA cannot help them to any real extent. He says he knows that those patients are not otherwise placed with another agency.

Response 11

It is not clear to what extent this comment relates to the period 2001-2005 or to more recent years. Moreover, Mr. Dial does not provide any specific data to support his belief that Medi-Cal eligible patients that his HHA was not able to serve didn't obtain services from another HHA or alternative provider type.

Comment 12

Mr. Dial says that when his HHA does agree to provide services to a Medi-Cal patient, the Medicare and private insurance reimbursement is subsidizing the Medi-Cal program due to failure of the Medi-Cal program to cover actual cost of performing the services.

Response 12

It is not clear to what extent this comment relates to the period 2001-2005 or to more recent years. It does not refute the data in the further rate review showing that Medi-Cal beneficiaries had sufficient access during 2001-2005.

Comment 13

Mr. Dial says that the 10% increase in HHA rates that took effect in August 2000 "was not driven by any work by the Department," but rather "through the cautious efforts and other efforts to get a legislative remedy to a disastrous rate situation in 2000." He further says that the 10% increase didn't help a lot and was a "band-aid" on a severe situation."

Response 13

DHCS appreciates that the provider community participated in the movement to obtain a 10% rate increase beginning August 2000. However, the Administration at the time was obviously involved in the process of assuring that the money to fund a 10% rate increase was included in the budget. Moreover, it was DHCS that promulgated the regulatory amendments incorporating a 10% rate increase into state regulation in accordance with the California Administrative Procedures Act.

Comments by Jason Grinstead (Care at Home Community Healthcare)

Comment 1

Mr. Grinstead cites a single statistic for the proposition that access for the Medi-Cal population declined for 2001-2005 as the eligible population expanded. Specifically, he calculates the difference between the percent of average monthly users relative to the fee-for-service eligible population was .249% in 2001 and .190% in 2005, a decline of 24%.

Response 1

As stated in responses to other comments, the number of users varied over the five years, and other data (e.g., Medi-Cal expenditures) showed a steady increase in the volume of services that HHAs were providing to beneficiaries they served. Moreover, DHCS believes any decline in the number of HHA "users" was more a result of available alternative providers that some beneficiaries (and perhaps their families) may have preferred (e.g., ADHCs, individual nurse practitioners, and personal care providers). Even if one were to conclude based on the available data that access for Medi-Cal beneficiaries declined during the period 2001-2005, it was better in all five years for Medi-Cal beneficiaries than Medicare beneficiaries as measured by the number of participating HHAs available to the eligible populations most likely to need HHA services.

Comment 2

Mr. Grinstead presents a table he prepared, which measures the number of Medi-Cal participating providers during 2001-2005 relative to the entire Medi-Cal fee-for-service population. This data shows that the while the number of Medicare eligible persons per each Medicare participating HHA declined during 2001-2005, the number of Medi-Cal fee-for-service eligible beneficiaries increased per each Medi-Cal participating HHA. His table also shows that while the number of Medicare participating HHAs for each Medicare eligible person increased during 2001-2005, there was a reduction in the number of Medi-Cal participating HHAs for each Medi-Cal fee-for-service eligible person during 2001-2005.

Response 2

As DHCS has explained in response to other comments, Medi-Cal eligible beneficiaries who are neither aged, blind, nor disabled are rarely going to need HHA services. Beneficiaries who are neither aged, blind, or disabled, do not typically have physical conditions of the type that generally require HHA services. Thus, in comparing Medi-Cal access to Medicare access in table 2 of the further rate review, DHCS focused on the number of Medi-Cal eligible persons who are most likely to need HHA services in comparing Medi-Cal access to Medicare access. As explained in the further rate review and in response to other comments, those persons most likely to need such services are those who are aged, blind, or disabled. This is a population of persons that is comparable to the group of persons eligible to Medicare.

Comment 3

Mr. Grinstead states that Medi-Cal rates are inadequate because they don't take into account provider costs, as does the Medicare program in setting its rates. He further contends that what he believes to be an access problem for 2001-2005 would have been alleviated if Medi-Cal rates were more comparable to Medicare rates.

Response 3

The Court of Appeal has held that section 1396a(a)(30)(A) does not require DHCS to set rates based on provider costs or to assure that rates compensate any particular percentage of provider costs. The objective of the further rate review was to determine if Medi-Cal beneficiaries had sufficient access during 2001-2005. If DHCS had concluded that there was an access problem during this period, then it might have been relevant to evaluate how rates during this period compared to provider costs or rates

paid by other payers such as Medicare, in an effort to resolve the problem. But, DHCS concluded there was not an access problem during this period.

Comment 4

Mr. Grinstead states that the further rate review was flawed because it failed to analyze regional differences in HHA costs.

Response 4

As noted previously, the Court of Appeal held that section 1396a(a)(30)(A) did not require DHCS to evaluate how rates paid to HHAs compared to the HHA costs of providing services.

Comments by Robert Leventhal (Law Firm of Foley and Lardner)

Comment 1

Mr. Leventhal contends that DHCS failed to comply with the court order or the statutory requirements. He provides more specific support for this contention in subsequent comments.

Response 1

DHCS disagrees with Mr. Leventhal's conclusion, and will provide responses to his more specific comments that are the apparent basis for his conclusion.

Comment 2

Mr. Leventhal contends that DHCS's conclusion about there being sufficient access during 2001-2005 ignores the data contained in the further rate review.

Response 2

DHCS disagrees with Mr. Leventhal's conclusion and will provide responses to his more specific comments that are the apparent basis for his conclusion.

Comment 3

Mr. Leventhal contends that DHCS somehow violated the March 2012 Court of Appeal decision by comparing data contained in the 2001-2005 period to data in the 1992-1997 period that was in the 1998 access study.

Response 3

What the Court of Appeal had a problem with was that the June 2008 rate review relied on the fact that there was sufficient access in the1998 study, which included data for 1992-1997, without evaluating comparable data for 2001-2005. DHCS addressed this problem by providing data for 2001-2005. There was nothing in the Court's decision that prohibited DHCS from comparing the data for 2001-2005 to the data for 1992-1997 that was in the 1998 study. In fact, Mr. Leventhal and other commenters have done exactly that.

Comment 4

Mr. Leventhal notes that the users as a percentage of the fee-for-service population for the 1992-1997 period increased, starting with a percentage of .13%, whereas the same statistic in the 2001-2005 period gradually went down to .19% in 2005. Thus, he says the data for 2001-2005 is a mirror image of what happened in 1992-1997.

Response 4

Mr. Leventhal focuses on a single statistic contained in Table 1 of the further rate review to argue that access deteriorated and, because he contends access deteriorated, there is an access problem. Moreover, a major difference with respect to the 1992-1997 data in the 1998 study is that the starting point statistic of .13% was very low and thus, there was much room for improvement. The percentage of average monthly users relative to the fee-for-service eligible population was at .18% as of 1995. The lowest point for the 2001-2005 periods was more than that at .19% in 2005. Moreover, the 1998 study found that most of the growth occurred between 1995 and 1997 because of a policy change authorizing home health care in the EPSDT program, and not as a result of a rate change.

As explained in DHCS's response to Zaretsky comment 7, there was not a steady decline in all the utilization data in Table 1 during 2001-2005. The number of users in 2003 and 2004 was significantly higher than in 2001-2002. The numbers of users varied during 2001-2005, as did the percentage of users of the eligible population. Some data (i.e., users as percentage of eligible population) was comparable in 2001 to 1997, the best year of the 1992-1997 period. Other utilization data was much better in

2001 than in 1997. As explained in DHCS's response to Zaretsky comment 4, HHAs in 2001 were providing three times the volume of services (as measured by expenditures) in the aggregate and for each user, compared to 1997. Also, as explained in response to Zaretsky comment 6, the volume of services provided in the aggregate and for each user continued to grow during 2001-2005. Thus, it is inaccurate to say that the data for 2001-2005 is the mirror image of what happened in 1992-1997. For the reasons set forth at pages 6-8 of the further rate review and in DHCS's responses to Zaretsky comments 8, 9, and 10, it was not unreasonable for DHCS to conclude that the drop in users in 2005 was related to persons who might otherwise get services from HHAs, choosing instead to receive services from alternative providers that met their healthcare needs (e.g., ADHCs, individual nurse practitioners, pediatric day providers, and personal care providers).

Finally, regardless of whether one views access as declining, remaining steady, or getting better during 2001-2005, the key issue is whether access remained comparable to that available to the general population and table 2 of the further rate review shows that it was comparable for all five years.

Comment 5

Mr. Leventhal contends that the data in the further rate review shows that there was inadequate access during 2001-2005.

Response 5

DHCS disagrees for the reasons set forth in the further rate review and in response to other comments.

Comment 6

Mr. Leventhal contends that DHCS continues to rely on data showing that while there was growth in the number of HHAs participating in Medi-Cal during 2001-2005, there was much greater growth in the number of HHAs participating in Medicare. He further states that because DHCS has continued to rely on this data, it shows that it has not listened to what the Court of Appeal said.

Response 6

On the contrary, DHCS heard what the Court of Appeal said with respect to the greater increase in HHAs participating in Medicare than in Medi-Cal during the period 2001-2005. In that regard, see pages 2, and 8-10 of the further rate review, and DHCS's

response to Zaretsky comment 2. In summary, DHCS considered the Court of Appeal's concern and investigated why there would have been greater growth in HHAs participating in Medicare and determined that it was because there is a need for more HHAs in the Medicare program because Medicare has a much greater population of persons most likely to need HHA services than Medi-Cal does.

Comment 7

Mr. Leventhal contends that units of service, as set forth in Table 1 of the further rate review is an arbitrary measure of volume of service because HHAs are likely submitting claims more frequently and often with fewer services included on each claim in an effort to get reimbursed by Medi-Cal more quickly. He contends that this illustrates that HHAs were submitting claims sooner and more frequently because of cash flow problems and that this shows the rates are not sufficient to cover their costs.

Response 7

Similar comments were made by Henry Zaretsky (comment 5), and David Dial (comment 4). In responding to Mr. Leventhal, DHCS incorporates the responses it made to Zaretsky comment 5 and Dial comment 4. With respect to his comment that HHAs were submitting claims more frequently because of cash flow problems and the insufficiency of rates to cover costs, there is no evidence that that is the reason some HHAs were submitting claims more frequently. Whatever the reason, they were providing services, and taking advantage of the fast payment turn around by the Medi-Cal claims processing system. Moreover, the Court of Appeal said section 1396a(a)(30)(A) does not require rates to be cost based or compensate all or any specific portion of a provider's costs.

Comment 8

Mr. Leventhal says that it was a mistake for DHCS to consider in Table 2 of the further rate review the number of beneficiaries in Medi-Cal and Medicare in relation to the number of participating HHAs in each program. He says the reason it is a mistake is because all it takes to become a Medi-Cal HHA is for the provider to fill out a form and if an HHA is already in business it is very easy to become a Medi-Cal provider whether or not it intends to provide many or even any services.

Response 8

As explained in response to Zaretsky comment 12 and Dial comment 5, the number of Medi-Cal participating HHAs in Table 2 of the further rate review is based on the number that billed the Medi-Cal program for services provided during each year. It is not based on the number of HHAs that merely filled out a form.

Comment 9

Mr. Leventhal contends that DHCS's own data shows that a higher percentage of Medi-Cal participating HHAs provided fewer than 60 visits annually to Medi-Cal beneficiaries than the percentage of Medicare participating HHAs that provided fewer than least 60 annually to Medi-Cal beneficiaries.

Response 9

This comment is referencing data that Mr. Zaretsky submitted and commented on, which is summarized in Zaretsky comment 15 (see DHCS response to Zaretsky comment 15).

Comment 10

Mr. Leventhal contends that what needed to be done in evaluating access is to "look at patients," and determine whether "Medi-Cal patients who need … home health treatment get it," "get all they need," and whether "they get it as easily as Medicare or as other patients in the community."

Response 10

In conducting the further rate review, DHCS evaluated data that it had in its possession, including the number of HHAs providing services to Medi-Cal beneficiaries, number of beneficiaries receiving HHA services, number of claims submitted, and the amount of money paid to HHAs during 2001-2005. It further compared provider participation in Medi-Cal and Medicare in relationship to the number of beneficiaries in each program most likely to need HHA services. DHCS does not maintain the sort of detailed data on the experiences of individual beneficiaries that Mr. Leventhal is talking about, especially back to 2001-2005.

Comment 11

Mr. Leventhal says that DHCS's explanation on pages 6-8 of the further rate review for why there was a drop in HHA users in 2005 is just speculation, and not supported by any data.

Response 11

See response to Zaretsky comments 8, 9, 10, and 11.

Comment 12

Mr. Leventhal says that "[t]his is something that can ruin people's lives" and "deserves a serious analysis to make sure that these people that are desperately in need of care are getting the care they need." He says DHCS 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. Thus, he says "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."

Response 12

Even if it could be established that there were Medi-Cal beneficiaries in 2001-2005 needing HHA services and wishing to receive HHA services who were unable to obtain HHA services, increasing rates to HHAs for that period is not going to resolve any such perceived access problem that occurred during 2001-2005. The further rate review does not reflect any "games with data." Rather, the further rate review presents relevant data, DHCS's analysis of the data, and DHCS's conclusion that Medi-Cal beneficiaries had sufficient access to HHA services during 2001-2005.

Comment 13

Mr. Leventhal contends that DHCS failed to look at whether Medi-Cal beneficiaries had access at least as good as that available to the general population.

Response 13

In response, see DHCS response to Zaretsky comments 2 and 3.

Comment 14

Mr. Leventhal said DHCS failed to look at the reason the gap was growing during 2001-2005 between the number of HHAs participating in Medicare and Medi-Cal.

Response 14

DHCS did look at that issue, as summarized at pages 8-10 of the further rate review. See also the response to Zaretsky comments 2 and 14, Dial comments 5 and 7, and Grinstead comment 2.

Comment 15

Mr. Leventhal contends that expenditures for HHA services per eligible person were down during 2001-2005.

Response 15

This is not correct. Medi-Cal expenditures for HHA services per fee-for-service eligible person tripled in the 2001-2005 period compared to what it was in 1997. Moreover, the amount of money being paid to HHAs per user steadily increased during 2001-2005, as did aggregate expenditures to HHAs (see DHCS' response to Zaretsky comment 6 for more detail).

Comment 16

Mr. Leventhal says that the further rate review demonstrates that that there was an access problem during 2001-2005 and that "any rational analysis of the data there shows an access problem" and "access getting worse during the time period in question."

Response 16

DHCS disagrees with Mr. Leventhal's conclusions. Based on the data and analysis contained in the further rate review, and based on the consideration it gave to public comments, DHCS believes it reasonably concluded that beneficiaries had sufficient access during 2001-2005.

Comment 17

Mr. Leventhal says that a rate increase for HHAs is not going to cost the state money. He says most likely it will save money because having patients treated at home by a home health professional is the most cost-effective way to treat them and avoids hospitalization and avoids serious complications. He further says "there's seriously disabled children and other beneficiaries that desperately need these services and don't want to be institutionalized." Thus, he says the state needs to do what it's been required to do for all these years and increase rates.

Response 17

These comments appear to relate to what Mr. Leventhal believes to be the insufficiency of current rates and the need to increase current rates. Such comments do not relate to the issue of whether beneficiaries had sufficient access to HHA services during 2001-2005.

Comments by Jarrod DePriest (Maxim Healthcare Services)

Comment 1

Mr. DePriest notes that his company has 27 licensed HHAs in California that currently provide services to 6,000 consumers on a weekly basis, including 1,300 Medi-Cal beneficiaries.

Response 1

DHCS greatly appreciates the services that the HHAs operated by Maxim Healthcare Services are currently providing to many Medi-Cal beneficiaries on a weekly basis.

Comment 2

Mr. DePriest notes that while there was steady growth in the number of HHA providers in Medi-Cal during 2001-2005, that "historical growth stands in stark contrast to more recent data, which shows a decline following a 2008 cut in reimbursement rates. He then provides data for 2008 and 2011 which he contends illustrates an access problem.

Response 2

This comment presents data relevant to whether there is a current access problem and does not specifically challenge DHCS's findings that there was sufficient access during 2001-2005.

Comment 3

Mr. DePriest presents data on the mean hourly wages for home health RNs and LVNs in 2011 relative to current rates paid to HHAs for home health visits by RNs and LVNs. He notes that the rates in 2011 barely compensate the mean hourly wages in 2011.

Response 3

This comment is related to the adequacy of current rates and not whether rates were adequate in 2001-2005. However, it is worth noting that the rates paid in 2011 are actually 1% less than what were paid in 2001-2005. So, if rates paid in 2011 exceeded the mean hourly wage of RNs and LVNs, than it is reasonable to conclude that the 1% higher rates in 2001-2005 likely exceeded hourly RN and LVN wages in that period by a greater margin.

Comment 4

Mr. DePriest states that most beneficiaries receiving hourly nursing support services are children at highest risk of institutionalization and that there are no subacute facilities that can service them, making hospitalization more likely.

Response 4

This comment appears to be related to the current situation and not the issue of whether there was sufficient access during 2001-2005.

Comment 5

Mr. DePriest states that when patients lose access to in-home services, the alternative care setting can be significantly more expensive for the state and other payers, and in support of this he presented information from a recent AARP study showing the higher cost in 2008 for nursing facility care compared to home and community based care.

Response 5

This comment appears to be related to the current situation and not the issue of whether there was sufficient access during 2001-2005.

Comment 6

Mr. DePriest states that his company evaluated claims submitted by home health providers and determined that there was a 14% drop in in the number of HHAs providing services when DHCS implemented a 1% reduction in rates.

Response 6

The Medi-Cal rates for HHAs were reduced by 1% effective March 1, 2009. Thus, this comment is related to the impact on access that occurred after 2001-2005.

Comment 7

Mr. DePriest says that he believes the time is ripe for payment reform models that encourage lower cost settings, and that the first step in this direction would be a claims data analysis that looks at the total cost of care for these patients across the various institutional and in home care settings.

Response 7

This comment is related to the current situation and not the issue of whether there was sufficient access during 2001-2005. DHCS appreciates Mr. DePriest's suggestions for payment reform models going forward and will consider them, as appropriate.

Comments by Ken Erman (RX Staffing and Home Care)

Comment 1

Mr. Erman says his mother started his HHA 22 years ago and has been licensed as a Medicare and Medi-Cal provider since 1996. He states that up until 2004, 90% of his HHA's business was from Medi-Cal. However, in about 2003 or 2004, his HHA began to reduce the percentage of its business devoted to Medi-Cal patients to a level today of about 10%.

Response 1

At least up until 2004, Mr. Erman's HHA was providing a much higher volume of services to Medi-Cal patients than Medicare patients. He began reducing the Medi-Cal portion of his business in 2004, and is at 10% Medi-Cal today. He does not indicate what portion of his business was devoted to Medi-Cal beneficiaries in 2004 and 2005. He also does not address the extent to which the reduction in the percentage of his business devoted to Medi-Cal could have been related to some beneficiaries choosing

to receive services from alternative providers discussed on pages 6-8 of the further rate review (e.g., ADHCs, individual nurse practitioners, and personal care service providers).

Comment 2

Mr. Erman states that the current HHA reimbursement rates are 1% lower than the rates paid during 2001-2005 and they are inadequate relative to the costs of providing services.

Response 2

This comment is related to current rates and not the issue of whether beneficiaries had sufficient access during 2001-2005.

Comment 3

Mr. Erman states that there is currently much less access to HHA services and gives reasons in support of that.

Response 3

This comment is related to the current situation and not the issue of whether beneficiaries had sufficient access during 2001-2005.

Comments by Catherine Johnston (ACT Home Health, Inc.)

Comment 1

Ms. Johnston forwarded a letter submitted to her by a mother of children for which her HHA provides in-home nursing care through the Medi-Cal EPSDT program. The letter from the mother discusses the home health needs of her children and states that nurses should get more pay at the home health agency.

Response 1

This comment is related to the current situation and not the issue of whether beneficiaries had sufficient access during 2001-2005.

Comment 2

Ms. Johnston also submitted another letter with her own comments. She first states that the further rate review failed to address the most poignant question which is "do the current reimbursement rates give providers the means to hire a sufficient quantity of staff to ensure beneficiaries are receiving all the services they are entitled to under the Medi-Cal program?" She believes the answer to that question is no.

Response 2

This comment is related to whether current rates are adequate and not the issue of whether beneficiaries had sufficient access during 2001-2005.

Comment 3

Ms. Johnston states that she is neither agreeing nor disagreeing with DHCS' position that there were sufficient HHAs to meet the existing needs of Medi-Cal beneficiaries. She says that the more appropriate measure of whether reimbursement rates are sufficient is to determine whether existing providers have sufficient staff to meet the needs of the beneficiaries.

Response 3

This comment is related to whether current rates are adequate and not the issue of whether beneficiaries had sufficient access during 2001-2005.

Comment 4

Ms. Johnston states that a great percentage of her HHA patients do not receive the services they are eligible for because she cannot hire staff to provide care. Specifically, she says her HHA does not fulfill 19% of the services physicians have ordered simply because her HHA cannot find nurses who are willing to work for the rates she can offer. She says that while home health private duty nurses understand and accept they will be receive less pay than in other settings (e.g., hospitals), most will not work for pay that is consistent with reimbursement rates established in the year 2000.

Response 4

This comment is related to whether current rates are adequate and not the issue of whether beneficiaries had sufficient access during 2001-2005.

Comment 5

Ms. Johnston states that it is unrealistic to expect HHAs to be able to operate in 2013 at the Medi-Cal reimbursement rates that were established in 2000. She further says the ability to maintain a viable business is timed to the willingness of nurses to accept substandard wages and as her HHA loses more and more nurses, the patients and families her HHA serves continue to experience greater losses of services, and substandard nurses as well. She says she cannot hire the best nurses when using poorest wages. She further states that when a nurse leaves, it can take months to find replacements because of low pay. Ms. Johnston notes that this situation is not addressed in the further rate review and that if rates remain inadequate, patients and families will continue to be undeserved or not served at all.

Response 5

This comment is related to whether current rates are adequate and not the issue of whether there was sufficient access during 2001-2005.