

HOME HEALTH AGENCY

THE DEPARTMENT OF HEALTH CARE SERVICES' (DEPARTMENT) MEDI-CAL HOME HEALTH RATE REVIEW WITH CONSIDERATION OF EFFICIENCY, ECONOMY, QUALITY OF CARE, AND ACCESS

PUBLIC COMMENTS AND THE DEPARTMENT'S RESPONSE

I. Public Comments Were Provided by the Following Interested Individuals/Organizations:

- A Binder with Written Comments Provided by Foley & Lardner LLP (F&L)
- Oral comments provided at the Public Hearing Held on August 11, 2008 (Transcript)
- Letter from Patti Sheldon, RN, Administrator of Antelope Valley Home Care, dated August 9, 2008, to Marie Taketa of Department of Health Care Services (Department)
- Letter from Nancy Giachino, RN, Administrator of Always Home Inc., dated July 28, 2005, to Joe Hafkenschiel of the California Association for Health Services at Home (CAHSAH)
- Letter from Blue Shield of California to Always Home Nursing Services, dated December 21, 2005
- Report of Henry Zaretsky, Ph.D., President of Henry W. Zaretsky & Associates, Inc., Sacramento, CA, dated August 8, 2008, prepared for CAHSAH

II. Oral/Written Public Comments AND Department's Responses

1. Home Health Agency (HHA) rate review does not analyze adequacy of Medi-Cal rates nor examine whether those rates were sufficient to enlist enough providers so that home health care and services are available to Medi-Cal beneficiaries at least to the same extent that the services are available to the general population.
 - Pages 1, 11, 12 of (F&L)
1. **Department's Response:** Data shows that the number of HHAs and the number of Medi-Cal beneficiaries served either remained constant or increased each year of the study. There is no data to support that access to HHA care is related to any particular number of HHAs. The Department concludes that HHA care was available to those Medi-Cal beneficiaries who needed the services.
2. The Department instead of performing a meaningful rate study, has simply cited irrelevant data (including data from the wrong decade). The only actual study on which the Department relies is a study performed by Tucker Alan, Inc., in 1998 which looked at the years 1988 through 1997. The rate study fails to comply with the requirement of the State Medicaid Plan, California law, federal Medicaid law, the California Court of Appeal's decision in *California Association for Health Services at Home (CAHSAH) v. Department of Health Services*, 148 Cal. App. 4th 696 (2007), or the Superior Court's writ of mandate.

CAHSAH and its members request that the Department start from square one and do an unbiased, meaningful analysis of the costs of providing home health care services on an annual basis from 2000 through the present.

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

- Pages 1, 2, 5, 6, 12, 18 of (F&L);
- Pages 3, 4, 11 of Transcript of Public Hearing held 8/11/08, comment of Robert Leventhal of F&L;
- Page 15 of Transcript of Public Hearing held 8/11/08, comment of Nancy Giachino, RN, owner of a home health agency called Always Home Nursing Services;
- Page 17 of Transcript of Public Hearing held 8/11/08, comment of Jason Grinstead, staff of Care At Home, a pediatric home health agency;
- Page 2 of the letter from Patti Sheldon of Antelope Valley Home Care, dated 8/9/08

2. **Department's Response:** The Department considers the 1998 Tucker Alan, Inc. review to be a valid reference point. The Tucker Alan review was a meaningful and valid study that was conducted in an unbiased manner. The Tucker Alan review was valid and reasonable as there were no challenges made to this review to indicate that the review was not a valid review. The Tucker Alan review demonstrated that there was adequate access to HHA services during the 1992-1997 period. A ten percent rate increase was provided for HHA services in 2000 which further would have demonstrated that there was adequate access to HHA services and such access would have carried forth during the 2001-2005 period.

3. Since the last increase of HHA services in 2000, numerous costs incurred by home health providers have substantially increased. Overhead, workers' compensation insurance, gas, and other costs incurred by home health providers increased significantly between 2000, 2005, and 2007. Gasoline costs have significantly risen since 2000. Since home health providers drive from client to client, the cost of transportation is a major expense.

- Pages 1, 3, 5, 16, 17 of (F&L);
- Pages 33 and 34 of Transcript of Testimony before the CA State Assembly, Budget Subcommittee #1 (November 16, 2005);
- Page 9 of Transcript of Public Hearing held 8/11/08, comment of Robert Leventhal of F&L;
- Page 2 of letter from Nancy Giachino of Always Home Inc., to CAHSAH, dated 7/28/05

3. **Department's Response:** The Department was mandated by court order to review the adequacy of reimbursement rates to HHAs for the period 2001 through 2005. Though costs as identified above may have increased, much of the increase did not occur until after 2005.

4. The Department should have surveyed Medi-Cal patients in need of home health services or hospital discharge planners who would have informed the Department that it has become increasingly difficult for Medi-Cal beneficiaries to obtain needed home health services.
 - Pages 2, 14, 15 of (F&L);
 - Pages 25 through 35 of Transcript of Testimony before the CA State Assembly, Budget Subcommittee #1 (November 16, 2005);
 - Page 5 of Transcript of Public Hearing held 8/11/08, comment of Robert Leventhal of F&L

4. **Department's Response:** Complaints from Medi-Cal beneficiaries, their families and other health care providers remain an accurate gauge for determination of access and quality of care. Complaints collected and analyzed in the aggregate provide a reasonable guide to the industry's performance and the Department's actions.

5. Home health care services enables hospitals and nursing facilities to discharge patients earlier, enables the seriously disabled individuals to avoid being institutionalized, and allows them to live more productive and independent lives.

Home health care is both more pleasant for the patient, who is able to live at home and more economical for the State. If a HHA cannot be located for a Medi-Cal patient who is ready for discharge from the hospital, the patient length of time in the hospital will be inappropriately increased and result in higher costs to the Medi-Cal program.

- Pages 2, 6 of (F&L);
 - Page 32 of Transcript of Testimony before the CA State Assembly, Budget Subcommittee #1 (November 16, 2005);
 - Page 6 of Transcript of Public Hearing held 8/11/08, comment of Robert Leventhal of F&L;
 - Page 14 of Transcript of Public Hearing held 8/11/08, comment of Nancy Giachino, RN, owner of a home health agency called Always Home Nursing Services;
 - Page 2 of the letter from Patti Sheldon of Antelope Valley Home Care, dated 8/9/08
5. **Department's Response:** The Department acknowledges that care in the home may be preferable to care in an institutional setting. However, data does not support that an increased number of HHAs is needed, nor does the data support that increased rates alone would increase the number of HHAs and/or increase access to care. The Department has a financial responsibility to weigh the costs of care at home and costs incurred from institutionalization.
 6. Decrease in availability of home health care services to Medi-Cal patients will also increase the overall costs incurred by the Medi-Cal program. Inadequate reimbursement of home health care providers will adversely impact the availability of such care and will increase Medi-Cal expenditures.

- Page 3 of (F&L)

6. **Department's Response:** Please see Department's response to number 5.

7. One of the main costs incurred by HHAs is cost of employing registered nurses and licensed vocational nurses. Nurses' wages have risen sharply due to inflation and severe nurse shortage. The nurse shortage was exacerbated by California's implementation of hospital nurse staffing ratios that became effective January 1, 2004. Nurse shortage has increased competition for, and cost of hiring, nurses.

Pages 1, 3, 4, 11, 16 of (F&L);

Page 8 of Transcript of Public Hearing held 8/11/08, comment of Robert Leventhal of F&L;

Page 6 of Report of Henry Zaretsky, Ph.D, dated 8/8/08

7. **Department's Response:** As noted in the Tucker Alan, Inc. review, data indicated that there was adequate access to HHA services which includes nursing services. During the period of 2001-2005, there was no data to indicate any rise in nursing salaries nor any nursing shortages caused access problems for Medi-Cal beneficiaries.

8. The increased attractiveness of hospital employment placed greater pressure on HHAs, making it harder and more expensive to retain and recruit high quality nurses.

- Page 8 of February 15, 2005 declaration of Gina Henning, R.N. in *CA Nurses Assoc. v. Governor of CA*;
- Page 9 of Transcript of Public Hearing held 8/11/08, comment of Robert Leventhal of F&L

8. **Department's Response:** During the period of 2001-2005, the period in which the Department was ordered by the court to conduct an annual review of Medi-Cal reimbursement rates paid to providers of home health care services, there is no compelling data to suggest that attractiveness of hospital employment resulted in shortage of nurses for HHAs or requiring HHAs to pay nurses higher salaries.

9. Wage data from the Bureau of Labor Statistics confirms nursing wages have substantially increased from 2000 to the present.

- Page 4 of (F&L)

9. **Department's Response:** The wage data from the Bureau of Labor Statistics may confirm that nursing wages have increased from 2000 to the present, however, the Department was ordered by the court to review reimbursement rates paid to providers of home health care services for the period of 2001-2005. During the period of 2001-2005, there is no compelling data that shows that nursing wages have substantially increased during that period.

10. Failure to raise Medi-Cal rates to cover the significant increases in the cost of providing home health services would be expected to result in a reduction in the Medi-Cal beneficiaries' access to home health services. For example, in 2001, there were 85 more home health providers that accepted Medicare than accepted Medi-Cal. By 2005, this gap more than doubled, with 188 more home health Medicare providers than home health Medi-Cal providers.

There is a need to increase Medi-Cal reimbursement for hourly shift rates for nursing services. In the past six years, ability to staff Medi-Cal patients has been reduced by over 50% due to inability to attract nurses for home health care services.

Private insurance rates have gone up since July 15, 2005. Blue Shield rate for LVNs is \$49.80 an hour and for RNs it is \$63 an hour. Blue Shield's rate for a home health visit is \$126 and Medi-Cal pays somewhere around \$74 per visit. There is a disparity between the access of care for the patient and what the nurses are able to be paid.

- Pages 5, 13, 17 of (F&L);
- Page 11 of Transcript of Public Hearing held 8/11/08, comment of Robert Leventhal of F&L;
- Pages 13 and 14 of Transcript of Public Hearing held 8/11/08, comment of Nancy Giachino, RN, owner of a home health agency called Always Home Nursing Services;
- Page 16 of Transcript of Public Hearing held 8/11/08, comment of Jason Grinstead, staff of Care At Home, a pediatric home health agency;
- Page 1 of the letter from Patti Sheldon of Antelope Valley Home Care, dated 8/9/08;
- Page 1 of letter from Nancy Giachino of Always Home Inc., to CAHSAH, dated 7/28/05;
- Letter from Blue Shield of California to Always Home Nursing Services, dated 12/21/05

10. **Department's Response:** The failure to raise Medi-Cal rates to cover the increases in cost of providing home health services would not necessarily result in a reduction in the Medi-Cal beneficiary's access to home health services. Comparing the number of Medicare patients accepted by home health providers to the number of Medi-Cal patients does not necessarily mean that more Medicare patients are accepted because Medicare rates are higher. HHA providers are reliant on Medicare reimbursement since a majority of HHAs provide services to the elderly and disabled who are usually eligible for Medicare. For those who are dually eligible for Medicare and Medi-Cal, a provider must bill for Medicare first, since Medi-Cal is a payer of last resort.

The Department does not have data to substantiate that staffing for Medi-Cal patients has been reduced due to an inability to attract nurses for home health services.

The Medi-Cal program is a social services program and cannot compete with rates paid by private insurance companies, such as Blue Shield. Since the Medi-Cal program is funded with public dollars, it must strive to be efficient and economical.

11. The Department raised rates for skilled nursing facilities (SNF) three times between 2000 and 2005. Since the major variable costs incurred by HHAs and SNFs are the same -- the cost of employing nursing staff -- there is no rational basis for raising rates for SNFs but not for HHAs.

- Page 6 of (F&L);
- Page 10 of Transcript of Public Hearing held 8/11/08, comment of Robert Leventhal of F&L;
- Page 8 of Report of Henry Zaretsky, Ph.D, dated 8/8/08

11. **Department's Response:** The Department agrees that there may be similarities in the types of services and variable costs that are incurred by SNFs and HHAs in order to provide services to Medi-Cal patients. However, the reimbursement methodology for SNFs is established in statute and regulations, and is based on costs while the reimbursement methodology for HHAs is not in statute, and is not based on costs. Since the reimbursement methodologies are completely different, it is not possible to compare the two reimbursement rates.

12. The Ninth Circuit Court of Appeals held in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997) that the Department must set rates that bear a reasonable relationship to an efficient and economical [provider's] costs in providing quality care. The Department must rely on responsible cost studies, its own or others that provide reliable data as a basis for its rate setting. The Department erroneously claims that the cost study requirement of *Orthopaedic* is no longer good law. The Department's legal argument is erroneous. Neither *Sanchez v. Johnson*, 416 f.3d 1051 (9th Cir. 2005) nor *Ball v. Rodgers*, 492 F.3d 1094 (9th Cir. 2007) held that the *Orthopaedic* requirement that rates be reasonably related to the costs of an efficient and economical provider was no longer in effect.
 - Page 7 of (F&L)

12. **Department's Response:** The comments are not persuasive and fail to rebut the information contained in the Rate Review (pp. 4-7). There is no controlling authority that requires Medi-Cal rates for home health services to be based upon provider costs. Applicable authority and the repeal of the Boren Amendment demonstrate the absence of such a requirement.

13. The Ninth Circuit reiterated the validity of the *Orthopaedic* standard in *Alaska Department of Health and Social Services v. Centers for Medicare & Medicaid Services (CMS)*, 424 F.3d 931 (9th Cir. 2005) by specifically relying on *Orthopaedic Hospital* and stated "We find no merit in the State's claim that there is no basis for cost-based review of state rate setting. To the contrary, our precedent plainly requires a state to set reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the state shows some justification for rates that substantially deviate from such costs." The Department's contention that "the 'efficiency and economy' language of the 'efficiency, economy, and quality of care' (EEQ) provision is that 'efficiency and economy' are an upper payment limit" is inconsistent with *Orthopaedic* and *Alaska*, and inconsistent with the plain language of the statute. If the language is an upper payment limit, then the Department could set the rates at zero without violating the statutory language. It would be absurd to claim that a payment of zero is "consistent with efficiency and economy." Plain meaning of the requirement that payments be "consistent with efficiency and economy" is that it sets both an upper payment limit and a floor. In its brief filed in the *Alaska* case, CMS agrees that the "efficiency and economy" language requires a finding that the "rates are neither too high nor too low." The Department failed to address whether the rates are too low to be consistent with EEQ provision.
 - Pages 8, 9, 10 of (F&L)

13. **Department's Response:** The comments are not persuasive and fail to rebut the information contained in the Rate Review (pp. 4-7). There is no controlling authority

that requires Medi-Cal to establish or assume upper and lower payment limits. Applicable authority demonstrates the absence of such a requirement. Although the Ninth Circuit in *Alaska Department of Health and Social Services v. Centers for Medicare & Medicaid Services*, 424 F.3d 931 (9th Cir. 2005) stated in dictum that its interpretation of the purpose of *Orthopaedic v. Belshe*, 103 F.3d 1491 (9th Cir. 1997) remains, it does not reference *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005). This fact is probably because *Sanchez* was not final when the Ninth Circuit issued the decision in *Alaska*. Also, *Ball v. Rodgers*, 492 F.3d 1094 (9th Cir. 2007) was issued after *Alaska* and is consistent with *Sanchez*. Additionally, in *Alaska* the federal government did not base its rejection of Alaska's state plan amendment on *Orthopaedic*, or because the rates were too low. Further, *Alaska* related to a dispute between the State of Alaska and the federal government over whether Alaska's reimbursement rates were too high and had nothing to do with whether rates complied with the payment standard set forth in *Orthopaedic*.

14. The Department relied on meaningless data when analyzing whether the rates are consistent with quality care. The data sources were the number of complaints about home health agencies received by the Department of Public Health, Licensing and Certification Division, and by the California Board of Registered Nursing. The Department did nothing to investigate quality of care, it merely compared the number of complaints received by these two agencies with the total number of home health visits during the years in question and concluded that the complaints were statistically insignificant. The number of complaints does not demonstrate that the rates are consistent with quality of care.
 - Page 11 of (F&L);
 - Page 4 of Report of Henry Zaretsky, Ph.D, dated 8/8/08
14. **Department's Response:** Complaints from Medi-Cal beneficiaries, their families and other health care providers remain an accurate gauge for determination of access and quality of care. Complaints collected and analyzed in the aggregate provide a reasonable guide to the industry's performance and the Department's actions. Therefore, the Department researched complaint data information as a possible indicator of whether quality of care issue was a problem. Tracking of complaints for the Licensing and Certification Division of the California Department of Public Health did not start until 2003; however, between the years 2003 through 2005, the percentage of complaints for HHA providers per-visit ranged from 0.099% to 0.131%. The California Board of Registered Nursing (CBRN) provided the Department with HHA RN complaints. Although CBRN was unable to differentiate Medi-Cal HHA complaints from other HHA complaints it was reported that the total number of HHA RN complaints are minimal.
15. In addition to looking at the wrong decade, the Department looked at the wrong states. The Department compared California's rates to the rates of a few other states – states with different economies than California. The Department did nothing to determine whether the rates in the other states are adequate to provide equal access to services and neglected to mention that some of those states substantially increased their rate after 2005.
 - Pages 12, 13 of (F&L)

15. **Department's Response:** Of the states that were used as a comparison, Medicaid rates range significantly different among the states. However, the Department found that California's rates for HHA procedure codes were comparable to other states with the exception of Texas. Since 2000, there were other states that either froze or decreased their rates during the period of 2000 through 2005, and Oregon had only minor increases in their rates since 2000. Since the Department was mandated by the court to review Medi-Cal reimbursement rates paid to provider of home health care services for the years 2001 through 2005 no comparisons were made after 2005.

16. In 2005, the California Legislature held hearings which addressed access to home health services. During the hearings, there was extensive testimony that Medi-Cal beneficiaries lack adequate access to Medi-Cal services. There was testimony that some Medi-Cal beneficiaries are unable to obtain all of the home health care that has been authorized by the Department. There was testimony that many home health providers turn away Medi-Cal beneficiaries because they cannot afford to treat them given the inadequacy of home health services' rates.

- Pages 15, 16 of (F&L)

16. **Department's Response:** The data researched by Tucker Alan, Inc. demonstrated that there was adequate access to HHA services. Based on the Tucker Alan, Inc. data, the Department found no direct causal relationship between increase in HHA rates and increasing access to services and care.

17. The Department has data that could be used to determine whether Medi-Cal patients have adequate access. The Department could examine the number of hours of shift nursing that it approved for a given time period and compare the hours approved with the hours delivered. If hours approved significantly exceed the hours delivered, the Department would know that there is an access problem.

In addition to the inability to fully staff authorized hours to Medi-Cal beneficiaries, new beneficiaries are regularly refused services because of the inadequate number of staff. On average each month, approximately four Medi-Cal patients who require shift nursing on a daily basis are turned away.

- Page 18 of (F&L);
- Pages 6 and 7 of Transcript of Public Hearing held 8/11/08, comment of Robert Leventhal of F&L;
- Page 2 of letter from Nancy Giachino of Always Home Inc., to CAHSAH, dated 7/28/05

17. **Department's Response:** Underutilization of approved HHA services does not necessarily indicate an access problem. There are many factors that determine whether or not a patient will actually receive the services authorized. For example, a Medi-Cal beneficiary's condition could have worsened which required hospitalization and, therefore, did not receive the home health services that were authorized.

18. Faced with serious allegations that nurse-to-patient ratios are impeding patient access to care, the Department must study what is happening. There is no concrete evidence

that implementation of the ratios has improved patient outcomes, and some evidence shows that the ratios have been disruptive to the health care system.

- Page 8 of February 15, 2005, Declaration of Gina Henning, R.N. in *CA Nurses Assoc. v. Governor of CA*

18. **Department's Response:** The Department has seen no reported data to suggest that nurse-to-patient ratios have had a negative impact on health care delivery.
19. The California State Legislature passed AB 394, (Kuehl, Chapter 945, Statutes of 1999) later amended by AB 1760 (Kuehl, Chapter 148, Statutes of 2000) that required the Department to develop minimum, specific, numerical licensed nurse-to-patient ratios for specified units of general acute care hospitals. It was determined that these are the minimum necessary to protect public health and safety.

The Department received four formal proposals for setting the ratios in acute care hospitals. The Department chose to take into consideration all of the perspectives of the four formal proposals in reaching a boarder, more objective consensus of workable, reasonable standards that would improve nurse staffing levels and quality of care to patients.

- Pages 1 through 41 of the Final Statement of Reasons of Department of Health Services in Rulemaking Procedure R-37-01, August 25, 2003

19. **Department's Response:** The Department appreciates the comments that were provided, but is unclear how nurse-to-patient ratios for general acute care hospitals impact HHAs.
20. In the transcript of the Testimony before the California State Assembly, Budget Subcommittee #1, Health and Human Services, November 16, 2005, Stan Rosenstein, the Department's Deputy Director for Medical Care Services, testified that Medi-Cal has been able to contain costs at a much better level than any other Medicaid program. A big factor that affects Medi-Cal is the lack of nursing home care coverage, either on the private market or in Medicare. Big expenditures are nursing homes, hospitals, and Medicare. Stan Rosenstein further stated that the Department is efficient, in terms of administration, as compared to the private industry. Since 2001, 2002, to the current day (November 2005), the Medi-Cal program has gone up by about \$3 billion. It is estimated that the Medi-Cal program runs about eight percent growth, between caseload and inflation, annually.

Per Stan Rosenstein, "Medi-Cal is the second largest item in the State's general fund. It is important for people to recognize that the cost of care in Medi-Cal per person varies very dramatically. Also notable is that two percent of the most expensive enrollees on Medi-Cal account for 40 percent of expenditures. These people have high-cost medical needs. Eligibility is also a major factor for the growth of the Medi-Cal program. We look at areas of Medi-Cal where we thought we paid too high of reimbursement rates. The laboratories were one of the targeted areas and the Department decreased reimbursement payments to reflect 80 percent of Medicare. However, there was no loss in laboratory services and access problems were not created."

“Lastly, in terms of cost containment is to better utilize federal funds. The Department has done a number of things over the last four years to improve the federal funds the Department gets for the Medi-Cal program.”

“In 2001, the Department gave a substantial rate increase, about a 16 percent increase. That was probably the first and only substantial rate increase that has been given since 1985. For physicians and other provider types, this was one comprehensive rate increase in 20 years.”

“Historically, the state has said that if there is more money, it is preferable to provide it on coverage, covering more people, rather than provider rate increases.”

Barbara Biglieri of CAHSAH had a member whose child receives Medi-Cal services through home health care benefits, and this member could not attend because her child’s nurse could not make the shift because the provider rates are insufficient. The home health care benefit allows the mother to be with her family, allows her to work, and not go on Medi-Cal herself. Until her son was two years old, her son was in an ICU every day which is an extreme cost to Medi-Cal. Living at home, her son was authorized 112 hours per week of HHA services however only 50 to 80 percent of the hours could be utilized because the nurses did not want to work for the rates that Medi-Cal paid.

- Pages 1 through 36 of Transcript of Testimony before the CA State Assembly, Budget Subcommittee #1 (November 16, 2005)

20. **Department’s Response:** The Medi-Cal budget is based on three competing factors, eligibility, benefits, and rates. Historically, the Department prefers to look at increasing eligibility in order to assist individuals and families to obtain health coverage. As a result, increasing benefits or reimbursement rates usually has not been as great a priority as increasing the number of individuals who are eligible.

21. Chart displaying Medicaid home health services rates for the State of Oregon for June 19, 2004.

Chart displaying Medicaid home health services rates for January 1, 2008.

- Pages 1 and 2 of (F&L’s) Exhibit G

21. **Department’s Response:** By comparing California’s Medi-Cal reimbursement rates for home health services to that of Oregon’s Medicaid reimbursement rates, it is clear that during 2004, California’s reimbursement rate for all services under home health was significantly higher than that of Oregon.

The second chart under Exhibit G of Foley and Lardner, LLP’s binder of comments shows a chart of home health rates effective January 1, 2008, however, there is no identification regarding this chart. If this chart belongs to Oregon’s updated Medicaid reimbursement rates for home health services, it shows that the reimbursement rates have significantly increased. The Department has no comments on this chart since the requirement of the court mandate was to review home health rates for the period of 2001 through 2005.

22. The rate review that the Department provided was focused on short-term intermittent visits and not long-term care, e.g., disabled children who are on ventilators to stay alive. These children could stay in a hospital, but it is much cheaper and beneficial to the child and family, and to the State for the child to stay at home. Private insurance for these children does not help because it may only provide for a few hours of care and then Medi-Cal must take over. However, the number of hours of home health care that is ordered by the child's doctor is not provided to the child because nurses are unwilling to work for the low rates that Medi-Cal reimburses. The result of this situation is that the child becomes unstable and returns to the ER. The State will have to bear costs that are dramatically higher if a child has to go to ER and ends up staying in a hospital.

If a HHA is only able to provide a child a portion of the home health services of what the doctor ordered, the doctor will refuse to have the child go home with HHA services because of the severe acuity of the child. The child usually needs a ventilator or other medical treatment that requires the child to be watched for as much as 22 hours a day.

- Pages 16 and 17 of Transcript of Public Hearing held 8/11/08, comment of Jason Grinstead, staff of Care At Home, a pediatric home health agency;
- Page 19 of Transcript of Public Hearing held 8/11/08, comment of Nancy Giachino, RN, owner of a home health agency called Always Home Nursing Service

22. **Department's Response:** The Department empathizes with the plight of children who are ventilator dependent and it is unfortunate that at times a child may have to go to the ER and spend time in the hospital. However, in its HHA rate review, the Department did not address situations regarding long-term care because the Department's main emphasis was to perform a general rate review for HHA services and not target specific situations.

23. Medi-Cal payment rates for HHA services are too low and negatively impacting access of patient to health care. In addition to fewer HHAs willing to accept and care for Medi-Cal patients, there are few physicians willing to care for those patients. There is a larger problem in that HHAs cannot accept a patient onto service without a physician willing to oversee the plan of care.

The cost of Antelope Valley Home Care of providing home health services to Medi-Cal beneficiaries is significantly higher than the Medi-Cal reimbursement rates for these services. Antelope Valley Hospital continues to operate the HHA and to provide services to Medi-Cal patients because it loses less money on patients who utilize home health services than it does to keep the patient inappropriately hospitalized.

- Page 2 of the letter from Patti Sheldon of Antelope Valley Home Care dated 8/9/08

23. **Department's Response:** During the period of review (2001-2005), there was an overall growth in HHAs that participated in the Medi-Cal program. Even without an increase in reimbursement rates since 2000-2001, the program continued to achieve high numbers of participating HHA providers who provided services to Medi-Cal beneficiaries and access for Medi-Cal beneficiaries was not demonstrated to be a problem for the time period 2001-2005.

24. Per Always Home Inc.'s letter of 2005, in the Sacramento area, the hourly pay rates for RNs and LVNs are the following: Acute care RNs are paid \$34 - \$47 and LVNs are paid \$24 - \$30. For SNFs, RNs are paid \$30 - \$40 and LVNs are paid \$22 - \$26. For home health services, RNs are paid \$25 - \$36 and LVNs are paid \$16.50 - \$20.

Since hospitals and SNFs offer much higher pay rates than skilled shift home nursing services, HHAs are not able to recruit adequate number of nurses. Failure to adjust home health care reimbursement annually makes home health care less competitive each passing year. While California healthcare providers have higher operating costs than most states, California ranks lower in terms of reimbursement to providers.

- Pages 2 and 3 of letter from Nancy Giachino of Always Home Inc., to CAHSAH dated 7/28/05

24. **Department's Response:** During the period of 2001 through 2005, a rate comparison was made of HHA services of other states and California. The comparison showed that California's reimbursement rates for HHA services were usually higher than most of the states that were compared. Furthermore, as noted in number 11 above, reimbursement rates cannot be increased across the board for all Medi-Cal services because different reimbursement methodology is used to establish the reimbursement rate of different types of providers and of providers in different types of clinics or facilities.

25. Per Dr. Zaretsky, according to Office of Statewide Health Planning and Development's Annual Utilization Report of HHAs in 2005, of the 794 HHAs reporting 60 or more total home health visits, the limited Medi-Cal participation rate reflects low Medi-Cal rates. Only 45% of HHAs have 60 or more Medi-Cal visits annually and 35% of HHAs provide no service to Medi-Cal beneficiaries. Medi-Cal expenditures for HHAs have declined between 2004 and 2006, while the number of Medi-Cal beneficiaries has remained constant.

- Pages 2 and 3 of Report of Henry Zaretsky, Ph.D, dated 8/8/08

25. **Department's Response:** Equating the number of HHA providers to low number of home health visits does not necessarily mean that this was due to low Medi-Cal reimbursement rates. This could be because there were more Medicare patients utilizing home health services.

26. Per Dr. Zaretsky, in 2005, Medi-Cal rates for home health visit services allowed a negligible number of agencies to recover their costs, and were set at approximately one-half median costs. The Department's strategy of freezing HHA rates at their 2000 levels flies in the face of its service authorization criteria under the Home and Community Based Services Waiver and the Early Periodic Screening Diagnosis and Treatment services, which require cost neutrality between HHA services and alternative post-acute services; generally more-costly inpatient SNFs. Through cutting real (i.e., inflation-adjusted) rates by 3% to 4% annually since 2000, the Department has caused access to these less costly home health services to decline.

By producing Attachment 10 to its Medi-Cal Home Health Rate Review, the Department has shown that it has had available cost data on HHAs since at least 2000 that could have formed the basis for annual rate studies.

- Page 9 of Report of Henry Zaretsky, Ph.D, dated 8/8/08

26. **Department's Response:** The basis of Attachment 10's data is CMS' annual Medicare data. There is a significant difference between the Medicare and Medi-Cal reimbursement system; e.g, the codes that are used and the structure of the systems. Medi-Cal reimburses on a per-visit basis with prior authorization dictating the number of visits. On the other hand, Medicare reimburses on the basis of diagnosis related groups where the patient's diagnosis dictates the number of HHA visits and the cumulative rate. While a Medicare rate for each visit could be determined, because the base and the assumptions are significantly different between Medicare and Medi-Cal, the Medicare per-visit rate for any Medi-Cal beneficiary could not be used as a basis for setting California's HHA service reimbursement rates.

27. Dr. Zaretsky provided a table titled "Medi-Cal Expenditures On Major Home Health Services 2000-2006. Also provided was a table titled "Medi-Cal Expenditures on Major Home Health Services Annual Rates of Change 2000-2006".

- Exhibit B, Tables B1 & B2 of Report of Henry Zaretsky, Ph.D, dated 8/8/08

27. **Department's Response:** Exhibit B, Tables B1 & B2 indicate that for some home health services there was a steady increase in the Medi-Cal expenditures from 2000 through 2004; however, between 2004 and 2005, there was a slight decrease in Medi-Cal expenditures though the number of eligible Medi-Cal beneficiaries remained relatively constant. The Department does not believe the slight decrease in Medi-Cal expenditures between 2004 and 2005 with a relatively constant number in Medi-Cal eligible beneficiaries is clearly indicative of diminished access to home health services for Medi-Cal beneficiaries. This slight decrease in Medi-Cal expenditures could have been for a number of reasons. For example, the decrease could have been attributable to the managed care expansion that has had an impact on various fee-for-service providers.

III. Department's Conclusion

The Department is appreciative of all the comments that were presented and submitted regarding the "Medi-Cal Home Health Rate Review with Consideration of Efficiency, Economy, Quality of Care, and Access". The Department considered and analyzed all of the comments, concerns, and requests that were submitted. The Department has determined that the comments submitted do not change the initial analysis of the Department in the June 2008 rate review and that the Medi-Cal reimbursement rates during 2001 through 2005 were not detrimental to access and the EEQ provision.