Medi-Cal Home Health Rate Review with Consideration of Efficiency, Economy, Quality of Care, and Access

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I
Background

This rate review was prepared to comply with the decision provided in *California Association for Health Services at Home v. Department of Health Services* (2007) 148 Cal.App.4th 696 (see Attachment 1.) In that decision the Court of Appeal held:

> The trial court is directed to issue a writ of mandate compelling the Department to conduct an annual review of the Medi-Cal reimbursement rates paid to the providers of home health care services for the years 2001 through 2005.

The Court of Appeal required the Department to perform a rate review consistent with the language set forth in the former State Plan at Attachment 4.19-B at page 20a.

Prior to the revision that occurred effective December 31, 2005, the California State Plan at Attachment 4.19-B at page 20a set forth the following language:

> The State Agency shall perform an annual review of the Medi-Cal reimbursement rates paid to providers of home health agency services. The purpose of such review is to ensure that the rates comply with federal regulation (sic) 42 U.S.C. section 1396a(a)(30)(A), which requires payments to be:
>
> 1) consistent with efficiency, economy, and quality of care; and
>
> 2) sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.[1] (see Attachment 2.)

This review complies with the decision in *California Association for Health Services at Home v. Department of Health Services* (2007) 148 Cal.App.4th 696.

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[1] Effective December 31, 2005, the language in the California State Plan at Attachment 4.19-B at page 20a, requiring an annual review of rates to ensure that rates comply with title 42 United States Code section 1396a(a)(30)(A) was deleted. The Plan provision was amended and now contains the following language:

> "The State developed fee schedule rates are the same for both public and private providers of home health agency services. The fee schedule and any annual or periodic adjustments to the fee schedule is published in California's Medi-Cal Inpatient/Outpatient Provider Manual at: www.medi-cal.ca.gov" (see Attachment 3.)

II
Data Sources

The data for the Department's Home Health Agency (HHA) review was obtained from the following sources:[2]

- Number of Complaints Received on Licensed HHAs by Calendar Year--Department of Public Health, Licensing and Certification, ACTS system. (see Attachment 5.)

- HHA Registered Nurses (RN) Complaints by year--California Board of Registered Nursing. (see Attachment 6.)

- Treatment Authorization Requests for Home Health--Department of Health Care Services (DHCS), Utilization Management Division. RF0-0-029a and data obtained from Business Objects xi. (see Attachment 7.)

- HHA Access Study dated June 1998 by Tucker Alan Inc. (see Attachment 8.)

- Rule Making File R-25-00E; Report No. 01-00-13 (Computation of Home Health Rates, Effective August 1, 2000); Cal. Code Regs., tit 22, section 51523, subd. (a). (see Attachment 9.)

The remaining data for the Department's HHA review were obtained from Myers and Stauffer LC. Their sources include the following:

- Medicare cost report data was used from the Centers for Medicare and Medicaid Services (CMS) freestanding and hospital-based HHA Healthcare Cost Report Information System (HCRIS) databases. (see Attachment 10.)

- Medi-Cal specific home health claims data was provided by Medi-Cal for dates of service calendar year 2001 through 2005. (see Attachment 11.)

- The MedPac March, 2004 report was used to validate results in some analyses. This report is titled, *MedPac, Report to the Congress: Medicare Payment Policy March 2004.* This report is issued by the Medicare Payment Advisory Commission (MedPac). (see Attachment 12.)

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[2] The Department requested data from a variety of sources, including other State departments and practice boards. Many of the departments/boards contacted did not have the data sought by the Department. Those requests and responses are provided in Attachment 4.

III
Analysis

Title 42 United States Code section 1396a(a)(30)(A) requires state Medicaid agencies to make payments for Medicaid covered services that are "consistent with efficiency, economy, and quality of care" (the "EEQ" provision) and "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population" (the "Access" provision). (see Attachment 13.)

A) The Efficiency, Economy and Quality of Care Provision

The sole guidance the United States Department of Health and Human Services (USDHHS) has provided with respect to compliance with the EEQ provision has been to adopt federal regulations that impose upper limits on spending (e.g., 42 C.F.R. section 447.300-447.334). The USDHHS has never interpreted the EEQ provision as requiring that reimbursement rates be based on provider costs or that rates compensate a reasonable portion or any specific portion of provider costs. Notably, the USDHHS has expressly rejected the proposition that the EEQ provision requires reimbursement to compensate any minimum portion of provider costs. For example, the USDHHS set forth its interpretation of the EEQ provision in adopting regulations to implement the then newly enacted Boren Amendment,[3] stating:

> The Medicaid law did not initially include any specific requirements regarding the methods of payment to be used to pay for either skilled nursing facility or intermediate care facility services. As a result, individual states were permitted to develop their own payment methods, subject only to **the general requirement** ... that payments not exceed reasonable charges consistent with **efficiency, economy, and quality of care**. Under the initial Medicaid law, states developed a variety of payment methods. These methods ranged from the retrospective, reasonable cost reimbursement system used by Medicare ... to prospective rates based, in some instances, on **state budgetary considerations** and other factors **not related to actual ... costs.** ((Emphasis added) 46 Fed. Reg. 47,964 (Sept. 30, 1981).)

[3] The federal law commonly referred to as the Boren Amendment was at former title 42 United States Code section 1396a(a)(13)(A) and provided in pertinent part that reimbursement rates for hospital inpatient services and long-term care facility services were to be "reasonable and adequate to meet the costs of efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards." Congress repealed the Boren Amendment effective October 1, 1997.

Thus, the USDHHS has construed the EEQ provision as imposing only a "general requirement" under which rates may be based on budgetary considerations and other factors unrelated to actual provider costs.

In a marked departure from the long-standing interpretation of the EEQ provision by the USDHHS, the United States Court of Appeals for the Ninth Circuit reviewed the EEQ provision in *Orthopaedic Hospital* v. *Belshe* (9th Cir. 1997) 103 F.3d 1491 (see Attachment 14) and found that the Department was required to "consider the costs of providing hospital outpatient services." (*Id.* at p. 1500.) The Court said that "the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting." (*Id.* at p. 1496.) The Court further required that, after considering the providers' costs, hospital outpatient rates "should bear a reasonable relationship to an efficient and economical hospital's costs in providing quality care." (*Id.* at p. 1500.) In the almost forty-year history of the EEQ provision, this is the first and only federal appellate court decision to interpret the EEQ provision to require states to consider provider costs and establish rates that bear some relationship to provider costs.

After the Department petitioned the Supreme Court for certiorari in *Orthopaedic*, the Supreme Court issued an order for the United States government to file an amicus brief. (*Belshe* v. *Orthopaedic Hosp (1997) 521 U.S. 1116.*) (see Attachment 15.) In November 1997, the Solicitor General filed an amicus brief on behalf of the USDHHS. A copy of the amicus brief filed on behalf of USDHHS is set forth in Attachment 16.

In that filed brief, the Solicitor General stated that the Ninth Circuit in *Orthopaedic* erred in "reading Section 1396a(a)(30)(A) as imposing on States an obligation to set payment rates for outpatient services that substantially reimburse providers their costs." (Attachment 16 at page 6.) In contrast to the Boren Amendment, "section 1396a(a)(30)(A) does not specifically require that the State consider providers' costs in setting Medicaid payments, much less 'meet' those costs." (Attachment 16 at page 13.). The Solicitor General further stated:

> Neither the Act nor any regulation promulgated by the Secretary 'gives any guidance' (*Blessing*, 117 S.Ct. at 1362) as to what portion of costs must be reimbursed by States for how many of the providers, or gives more specific content to the statutory criteria of **'efficiency, economy, and quality of care'** so that those criteria could be enforced by the court. Accordingly, the 'right assertedly provided by the statute is ... so vague and amorphous that its enforcement would strain judicial competence.' *Id.* At 1359 (quoting *Wright* v. *Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 431-432 (1987)). (emphasis added.) (Attachment 16 at page 15.)

More importantly, the Ninth Circuit has recently revisited the issue of what section 1396a(a)(30)(A) means for rate setting under the Medi-Cal Program. On August 2, 2005, the Ninth Circuit issued a new decision concerning section 1396a(a)(30)(A). (*Sanchez, et al.* v. *Johnson, et al.* (9th Cir. 2005) 416 F.3d 1051.) (see Attachment 17.) In *Sanchez*, the Ninth Circuit addressed an issue that was not addressed in *Orthopaedic*, by holding that neither the "access" provision nor the "EEQ" provision of section 1396a(a)(30)(A) create a judicially enforceable "right" for Medicaid beneficiaries or providers. (*Id.* at 1059-1060.) Regarding the statute's EEQ provision, *Sanchez* also noted:

> **The most efficient and economical system of providing care may be one that benefits taxpayers to the detriment of Medi-Cal providers and recipients; likewise the provision of 'quality' care—whatever standard may be implied by such a nebulous term—is likely to conflict with the goals of efficiency and economy.** (*Id.*) (emphasis added.)

Thus, the Ninth Circuit rejected *Orthopaedic's* interpretation of the EEQ provision as imposing any cohesive minimum standard related to the reasonableness of rates.

The *Sanchez* decision effectively overturned the *Orthopaedic* court's interpretation of section 1396a(a)(30)(A). As the Court further stated,

> The language of § 30(A) is similarly ill-suited to judicial remedy; the interpretation and balancing of the statute's indeterminate and competing goals would involve making policy decisions for which this court has little expertise and even less authority. (*Id.* at p. 1060.)

Thus, the Ninth Circuit rejected two aspects of the decision issued by the Ninth Circuit in the *Orthopaedic* case. First, by stating that the United States Court of Appeals has insufficient "expertise and even less authority" to interpret and balance the statute's "indeterminate and competing goals," the Court rejected what the Ninth Circuit panel did in *Orthopaedic*, which was to attempt to interpret the statute and balance the standards of efficiency, economy, and quality of care as imposing a cohesive cost-based minimum standard of reimbursement.

Second, by stating that the statute was "ill-suited to judicial remedy," it further rejected what the Ninth Circuit panel did in *Orthopaedic*, which was to issue a judicial mandate requiring DHCS to establish rates for hospital outpatient services in a particular manner.

Note also in *Ball* v. *Rodgers* (9th Cir. 2007) 492 F.3d 1094, 1115, the United States Court of Appeals reaffirmed *Sanchez* and stated that it did not believe any court

had the expertise or authority to interpret and balance the indeterminate and competing goals of section 1396a(a)(30)(A). (see Attachment 18.) The Court indicated that because section 1396a(a)(30)(A) "would require a court to account for numerous, largely unquantifiable variables – 'efficiency, economy, and quality of care,'" it did not believe that it could be capably enforced by a court. (Id.)

1) Efficiency and Economy

As noted previously, the United States Court of Appeals for the Ninth Circuit recently observed that "the most efficient and economical system of providing care may be one that benefits taxpayers to the detriment of Medi-Cal providers and recipients." (*Sanchez* v. *Johnson, supra,* 416 F.3d 1051, at p. 1060.)

The common sense interpretation of the "efficiency" and "economy" language supports the conclusion that "efficiency" and "economy" means paying the *lowest rate* possible or practicable for the program service or benefit. To conclude "efficiency" or "economy" as imposing a recognized minimum rate payment is without merit and would be inconsistent with longstanding federal administrative guidance and with recent Ninth Circuit authority. The most reasonable conclusion in interpreting the "efficiency" and "economy" language of the EEQ provision is that "efficiency" and "economy" are an upper payment limit that serves the states and the federal government in the effort to control program costs.

Conclusion:

The Department concludes that the rates for Home Health Services for years 2001 through 2005 do not violate any upper limit imposed by "efficiency" or "economy" within the ambit of the EEQ provision.

2) Quality of Care: Home Health Complaints

While agreeing with the recent decisions by the Ninth Circuit Court of Appeals in the *Sanchez* case and the *Ball* case, the Department nevertheless sought and obtained data that may relate to the "quality of care" language set forth in the EEQ provision. The Department focused upon complaint information data relating to quality of care.

i) Table 1

In an effort to obtain possible indicators relevant to the quality of care of HHA providers, the Department requested complaint data from the Department of Public Health (DPH), Licensing and Certification Division (L&C). Unfortunately, L&C instituted a new complaint tracking system in 2003, and consequently data prior to 2003 is not available. The information obtained from that effort is set forth in Table 1 below.

Table 1 HHA** Complaints by Year Calendar Years 2003-2005			
Location Received	**2003**	**2004**	**2005**
Application Support Unit	2		
Bakersfield-Support Staff	5	4	2
Chico-Support Staff	5	2	7
Daly City-Support Staff	5	4	8
East Bay-Support Staff	26	1	15
East Bay-Survey Staff	2		
Fresno-Support Staff	8	9	10
Fresno-Survey Staff			3
LAHHA -Support Staff	67	7	91
LAHHA-Survey Staff	9	100	1
Orange County-Support Staff	4	1	2
Riverside-Support Staff	8	1	10
Sacramento North-Support Staff	2		1
Sacramento North-Survey Staff	7	6	
Sacramento South-Support Staff	12	27	20
San Bernardino-Support Staff	8	1	36
San Diego North-Support Staff	7	26	29
San Diego North-Survey Staff	2	30	
San Jose-Support Staff	5	16	4
Santa Rosa-Support Staff	6	6	3
Santa Rosa-Redwood Coast-Support	1	4	
Ventura-Support Staff	11	6	1
Unassigned			1
Total Intakes	202	251	244

*L&C began capturing all complaints into ACTS database 2003.
Complaints prior to 2003 are unavailable.
** Licensed HHA included providers that provide Medicare services only, Medi-Cal services only, and both Medi-Cal and Medicare.

Note that L&C licenses not only Medi-Cal HHA providers, but also Medicare-only providers in California. L&C is unable to differentiate Medi-Cal HHA complaints from Medicare HHA complaints. Thus, the data contained in Table 1 above is not limited to only Medi-Cal HHA providers. Total complaints are relatively.

ii) Table 2

Table 2 below sets forth the number of Medi-Cal visits for home health services with the total number of complaints for each relevant year.

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Table 2 Total HHA Visits vs. HHA Complaints			
Calendar Year	**# of Medi-Cal Visits (A)**	**Complaints (B)**	**Complaints/ Visit**
2001	169,819	N/A	-
2002	187,779	N/A	-
2003	204,601	202	0.099%
2004	196,371	251	0.128%
2005	186,392	244	0.131%
Average	**188,992**	**232**	**0.119%**
Data Sources: (A) Visits data provided by Myers & Stauffer LC. (B) Complaint data provided by DPH L & C ACTS Database			

Note again the total number of yearly complaints is not limited to only Medi-Cal HHA providers. Even assuming every complaint was a Medi-Cal complaint, the percentage of complaints per visit range from 0.099% to 0.131%. Thus, the percentage of complaints in comparison to the total Medi-Cal HHA visits is minimal and does not indicate a quality of care problem relating to Medi-Cal rates.

iii) Table 3

The Department also contacted several professional boards to obtain HHA complaints. The following agencies were contacted: California Board of Registered Nursing, Physical Therapy Board of California, Speech-Language Pathology and Audiology Board, Board of Occupational Therapy, and Board of Vocational Nursing and Psychiatric Technicians. Unfortunately, except for the California Board of Registered Nursing, the agencies were unable to provide HHA specific complaints as they do not collect employment information on their licensees. See Table 3 below.

Table 3 HHA RN Complaints by Year Calendar Years 2001-2005	
Year	**# of Complaints**
2001	16
2002	15
2003	13
2004	16
2005	15
Data Source: California Board of Registered Nursing *Includes RN complaints from all payers.	

The California Board of Registered Nursing (CBRN) provided the Department with HHA RN complaints. However, the CBRN is unable to differentiate Medi-Cal HHA complaints from other HHA complaints as they do not track that information. Nevertheless, the total number of HHA RN complaints are minimal and support the conclusion that the rates paid for HHA services are consistent with the quality of care language in the EEQ provision.

Conclusion:

Based upon available data, the Department concludes that complaints pertaining to Home Health Services for years 2001 through 2005 (even if all were solely Medi-Cal related) are statistically insignificant. Thus, the Department's rates for Home Health Services for years 2001 through 2005 were consistent with the quality of care language set forth in the EEQ provision.

B) The Access Provision

Although it remains an open question whether an objectively verifiable causal connection exists between Medi-Cal rates and the adequacy of "access" to Home Health Agency services, the Department sought and obtained data for this rate review. The following review provides a summary of that information.

1) Table 4

To determine whether there was adequate access to HHA services, the Department reviewed the HHA Access Study dated June 1998 by Tucker Alan Inc. In this study, Tucker Alan found that over the 1992-1997 period, users as a percentage of eligibles doubled and HHA expenditures more than tripled. See table 4 below.

Table 4 Medi-Cal Expenditures and Eligibles				
		Medi-Cal Home Health		
Calendar Year	Medi-Cal Eligibles	Expenditures	Users	% of Medi-Cal Users
1992	4,383,978	$ 17,559,354	5,752	0.13%
1993	4,720,244	$ 20,201,248	7,216	0.15%
1994	4,903,150	$ 24,588,458	7,967	0.16%
1995	4,720,764	$ 27,307,130	8,682	0.18%
1996	4,380,337	$ 39,340,027	9,726	0.22%
1997	3,653,955	$ 61,922,359	9,363	0.26%
Data Sources: *HHA Access Study dated June 1998 by Tucker Alan Inc. and Medi-Cal Services and Expenditures Month-of-Payment Reports for Calendar Years 1992-1997.*				

The increases in expenditures, users as a percentage of eligibles, and expenditures per user during the 1992-1997 time period indicated an expansion of Medi-Cal HHA services. Notably, the Tucker Alan study further concludes that there was adequate access to HHA services during the 1992-1997 period.

2) Table 5

In budget year 2000-2001, the Department increased HHA rates by 10%. See table 5 below.

Table 5 2000-2001 10% Rate Increase for HHA			
Procedure Code	**Description**	**Previous Rate**	**Rate Effective 8/1/2000**
Z6900	Skilled Nursing Services	$68.05	$74.86
Z6902	Home Health Aide Services	$41.59	$45.75
Z6904	Physical Therapy Services	$62.58	$68.84
Z6906	Occupational Therapy Services	$64.87	$71.36
Z6908	Speech Therapy Services	$71.30	$78.43
Z6910	Medical Social Services	$87.47	$96.22
Z6914	Case Evaluation and Treatment Plan	$27.39	$30.13
Z6916	Monthly Case Evaluation/ Extension of Treatment Plan	$13.81	$15.19
Z6920	Early Discharge Visit	$68.05	$74.86
Data Sources: *Rule Making File R-25-00E* *Report No. 01-00-13 (Computation of Home Health Rates, Effective August 1, 2000)* *Title 22, Section 51523(a)*			

Notably, even after the expansion of Medi-Cal HHA services of 1992-1997 and adequate access to HHA services, the Department increased HHA rates by 10%. Thus HHA services access is not rate-driven.

3) Table 6

In an effort to compare Medi-Cal HHA rates to other states' Medicaid rates, the Department reviewed the Myers and Stauffer LC. State Rate Summary. Myers and Stauffer surveyed Florida, Oregon, Texas, Arizona, Illinois, and Washington to obtain their Medicaid HHA rates. In comparing Medi-Cal rates to a flat rate average of the other states, Medi-Cal rates either exceeded the flat rate averages or were very close to the averages.

Table 6

Medi-Cal Home Health Agency Comparison State Rate Survey Summary

2000-2001

State	Skilled Nursing Care Visit	Physical Therapy Visit	Occupational Therapy Visit	Speech Pathology Visit	Home Health Aide Visit
Florida [1]	$28.62	$13.58 to $48.50	$13.58 to $48.50	$13.58 to $48.50	$17.46
Oregon	$59.51	$59.51	$68.27	$65.35	$59.51
Texas	Full Cost	Full Cost	Full Cost	Full Cost	Full Cost
Arizona [2]	$22.01 to $71.47	$29.13 to $61.54	$28.77 to $61.54	N/A	$30.61
Illinois	$65.25	$65.25	$65.25	$65.25	$65.25
Flat Rate Ave [4]	**$51.13**	**$62.38**	**$66.76**	**$65.30**	**$43.21**
Medi-Cal	**$74.86**	**$68.84**	**$71.36**	**$78.43**	**$45.75**

2001-2002

State	Skilled Nursing Care Visit	Physical Therapy Visit	Occupational Therapy Visit	Speech Pathology Visit	Home Health Aide Visit
Florida [1]	$30.19	$13.58 to $48.50	$13.58 to $48.50	$13.58 to $48.50	$18.60
Oregon	$59.51	$59.51	$68.27	$65.35	$59.51
Texas	Full Cost	Full Cost	Full Cost	Full Cost	Full Cost
Arizona [2]	$22.82 to $74.11	$34.65 to $69.43	$36.01 to $70.22	N/A	$30.61
Washington (Ave) [3]	$84.49	$76.70	$70.52	$83.28	$45.74
Flat Rate Ave [4]	**$58.06**	**$68.11**	**$69.40**	**$74.32**	**$38.62**
Medi-Cal	**$74.86**	**$68.84**	**$71.36**	**$78.43**	**$45.75**

2004-2005

State	Skilled Nursing Care Visit	Physical Therapy Visit	Occupational Therapy Visit	Speech Pathology Visit	Home Health Aide Visit
Florida [1]	$28.62	$13.58 to $48.50	$13.58 to $48.50	$13.58 to $48.50	$17.46
Oregon	$62.85	$58.64	$63.92	$64.01	$29.49
Texas	$98.42	$113.45	$115.65	$116.62	$45.85
Arizona [2]	$24.43 to $79.31	$38.92 to $73.90	$45.13 to $78.65	N/A	$32.76
Illinois	$61.34	$61.34	$61.34	$61.34	$61.34
Washington (Ave) [3]	$84.49	$76.70	$70.52	$83.28	$45.74
Flat Rate Ave [4]	**$67.14**	**$77.53**	**$77.86**	**$81.31**	**$38.77**
Medi-Cal	**$74.86**	**$68.84**	**$71.36**	**$78.43**	**$45.75**

Data Sources:

All rates were arrived at through a combination of telephone surveys of various state Medicaid personnel (performed by Myers and Stauffer) and published state Medicaid rules / rate charts. We attempted to obtain per visit Medicaid rates for home health services. Based on the variation in rates, it is obvious that many states are including other home health services or are paying for different time intervals.

[1] Florida had different rates for RNs and LPNs and there were mid-year changes in the rates during some years. These different Skilled Nursing rates were averaged to arrive at the above rates. The therapy rates range depending on who performs the service and the type of visit. The range of therapy rates are shown above.

[2] Arizona has a range of rates for Skilled Nursing depending on the type of visit and the type of provider. Arizona pays therapy visits under their physician fee schedule and the fees range depending on the type of

service provided at each visit. The rates for therapies shown above are from the fee schedule for evaluations.
[3] Washington sets different rates for different geographic areas. The rates above reflect a simple average of the rates at July 1, 2005 reduced by 1%.
[4] Only includes those with a single rate, shown above, in the average; ranges were excluded.

Medi-Cal rates are comparable to other state Medicaid rates with the exception of Texas. Medi-Cal exceeds Florida in every procedure matched, and exceeds Oregon except for Home Health Aides.

California is not the only state that has frozen rates since 2000. Other states have frozen or even decreased rates over the 2001-2005 time period. Florida reduced their 2005 rates back to 2000 levels. Washington froze their 2005 rates to 2001 levels. Illinois reduced their rates in 2005 by 6%, which is less than their 2000 levels. Thus, Medi-Cal rates are very comparable and in line with other states' Medicaid rates.

4) Table 7

The number of Medi-Cal participating HHA providers from Medi-Cal claims data was compared to the number of California Medicare participating HHA providers from Medicare cost reports.

The average number of California Medicare HHA providers for the 2001-2005 period is 580 while the average number of Medi-Cal HHA providers is 421 for the 2001-2005 period. HHAs are typically highly reliant on Medicare reimbursement, since the majority of their users are over 65 years of age or disabled and thus are on Medicare. See Table 7 below.

Table 7
Comparison of California Home Health Agency (HHA) Medicare Participating Providers and Medi-Cal Participating Providers

	(A)	(B)		
Calendar Year	**Calif. Medicare HHA Providers**	**Medi-Cal HHA Providers**	**Percentage Growth in Calif. HHA Providers**	**Percentage Growth in Medi-Cal Calif. HHA Providers**
2001	504	419		
2002	530	427	5%	2%
2003	599	415	13%	-3%
2004	632	396	6%	-5%
2005	637	449	1%	13%
Averages	**580**	**421**	**6%**	**2%**
Total Growth 2001-2005			**26%**	**7%**

Data Sources:
(1) *Medi-Cal specific home health claims data was provided by Medi-Cal for dates of service beginning during the calendar year. The claims data was not reviewed or audited in any manner to determine its accuracy.*
(A) *California home health agency Medicare provider counts are based on the number of unique provider numbers that filed a Medicare cost report with a year overlapping the calendar year.*
(B) *Medi-Cal home health agency provider counts are based on the number of unique Medi-Cal provider numbers that submitted Medi-Cal home health claims with a beginning date of service during the calendar year.*

Overall growth in participating HHAs for the 2001-2005 period was 7% for Medi-Cal. Medi-Cal continues to achieve high numbers of participating HHA providers and is increasing, even without a rate increase since 2000.

5) Table 8

The Department reviewed the number of HHA Treatment Authorization requests (TARs) approved over the 2001-2005 period. Total HHA TARs and the number of approvals increased slightly while the average processing time decreased. Thus the TAR processing is not inhibiting Medi-Cal beneficiary access to home health services.

Table 8
Treatment Authorization Requests for Home Health
Calendar Years 2001 - 2005

Calendar Year	TARs Received	TARs Approved**	%	TARs Processed	%	Avg. Proc***
2001	33,210	20,088	60.49%	32,564	98.05%	8.6
2002	34,701	21,113	60.84%	34,442	99.25%	6.9
2003	38,113	22,845	59.94%	37,158	97.49%	6.8
2004	37,099	24,977	67.33%	36,697	98.92%	6.1
2005	39,476	24,198	61.30%	39,093	99.03%	2.0

***Average Processing Time in days: Source: RF0-0-029a (CY 1999 - 2005) and Data obtained from Business Objects xi on 12/14/07 by Patty Self.
Note: Percentage figures are percents of total received.
**TARS approved without modification or deferral.
Most data is available as "services," or lines/requests on TARs.
Data indicates approximately 1.558 services per TAR.
*Data obtained by dividing number of "services" by 1.558 to obtain number of TARs.

Conclusion:

Based upon the review of the data collected, the Department has concluded that the Medi-Cal Home Health Agency rates paid for years 2001 through 2005 were

sufficient to enlist enough providers so that care and services were available at least to the extent that such care and services were available to the general population in the geographic area.

IV
Conclusion

This review was conducted in accordance with former Attachment 4.19-B, Page 20a of the State Medicaid Plan regarding efficiency, economy, and quality of care, and access with respect to the rates paid for Home Health Agency Services for calendar years 2001 through 2005.

As Chief Deputy Director of Health Care Programs, I have the authority to adopt the above review on the Department's behalf, and hereby do so.

June 11, 2008

Stan Rosenstein
Chief Deputy Director of Health Care Programs
Department of Health Care Services