RESPONSE TO DEPARTMENT OF HEALTH CARE SERVICES "MEDI-CAL FURTHER RATE REVIEW OF ACCESS TO HOME HEALTH AGENCY SERVICES FOR 2001-2005"

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I. INTRODUCTION

Scope of Department's Review

The "Medi-Cal Review of Access to Home Health Agency Services for 2001-2005," ("Review") was prepared by the Department of Health Care Services ("Department") pursuant to an order by the California Court of Appeal to further review whether Medi-Cal beneficiaries had sufficient access to home health services in 2001-2005 in accordance with Section 1396a(a)(30)(A).

The analysis underlying the Review is presented in two parts: (1) Utilization Data for 2001-2005; and (2) Provider Comparison between Medi-Cal and Medicare. My response is presented in the same general format, to facilitate a comparison between the Review's approach and mine. In short, both the utilization data and the provider-comparison data conclusively demonstrate that access has worsened since 2001.

Conclusions

Notwithstanding that the data presented in the Review show an access problem, the Review ignores its own data and reaches a conclusion that is contrary to its own data. It claims that: (1) access has not worsened since 2001; and (2) access over the period 2001 to 2005 was sufficient.

This claim directly contradicts the data presented in the Review. Thus, the findings fail to meet the statutory criteria in 1396a(a)(30)(A); namely 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 analysis suffers from two crucial defects: (1) the correct issue wasn't addressed. The federal statute requires a comparison of access between Medi-Cal beneficiaries and the general public, which the Review did not consider; and (2) the data presented in the Review show worsening access since 2001, as opposed to the adequate access alleged. The Review's utilization data show that expenditures per Medi-Cal beneficiary and home-health users (i.e., patients) per beneficiary dropped significantly since 2001. And the data underlying its comparison of Medi-Cal and Medicare provider participation demonstrate worsening access for Medi-Cal beneficiaries relative to Medicare enrollees.

- The correct issue was not addressed. To comply with section 1396a(a)(30)(A), the Review should have compared access for Medi-Cal beneficiaries with access for the general public. An access study meeting the requirements of Section 1396a(a)(30)(A) would logically include analyses of Medi-Cal-beneficiary needs and those of the general public for home health services, and the degree to which these needs have been met (e.g., length of time from request for service to provision of service, difficulty in placing patients and unmet needs). The Department has access to much of the necessary data involving Medi-Cal, which could be supplemented with surveys based on samples of providers, addressing Medi-Cal and the general public. As cited in the Review, "The Access provision of 42 United States Code section 1396a(a)(30)(A) requires that payments to providers be '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 in the geographic area.'"[1] (Emphasis added.) Rather than conduct a study that attempts to compare Medi-Cal and the general public in terms of needs for service and the extent to which those needs are met, the Review simply assumes that Medi-Cal access, as

[1] Op. cit., Footnote 1, p. 3.

measured by utilization in 2001, was adequate, without any analysis, and then attempts to justify the worsening in access since 2001, shown by its data, through speculation and anecdotal observations.

- The data presented in the Review show that there has been a deterioration in access since 2001. When compared to data from the Department's 2008 Rate Review, which placed major reliance on data from 1992 to 1997, access has even worsened from 1997 to 2001. Moreover, when combined with additional data readily available in various Department reports, the deterioration in access is even more pronounced, based on the Review's own measurement approaches (i.e., number of agencies available to Medi-Cal beneficiaries, users per beneficiary, and expenditures per beneficiary).

- In addition to these crucial defects, under the Appeal Court's reasoning, if the Department can show that Medi-Cal beneficiaries had access to home health services equal to that of the general population, it could be assumed that the rates paid were not too low, and no consideration of costs is mandated. Since, however, the Department could not show that Medi-Cal beneficiaries had access equal to that of the general population, and in fact demonstrated the opposite, it cannot be assumed that the rates were adequate. Where an access problem exists, it is incumbent on the Department to attempt to determine the cause of the access problem. Thus, it is necessary to consider costs to determine if the access problem is due to inadequate rates. Based on data from home health agencies' Medicare Cost Reports, Medi-Cal payment rates in 2005 were for most services less than half of costs. Given that nearly all home health agency costs are variable, since they are overwhelmingly labor and travel related, agencies don't have the ability to spread their fixed costs over more patients whose payments are substantially below costs. Thus, their only means to maintain financial viability is to accept fewer Medi-Cal patients, and thus limit access. If the Department believes rates were not the cause of the access problem shown by the data presented in its Review, it has the responsibility to advance and justify an alternative explanation, which it has not.

II. UTILIZATION DATA FOR 2001-2005

Table 1 in the Review presents data for 2001-2005 on fee-for-service (FFS) Medi-Cal eligibles, average monthly users, annual expenditures, units per user and users as a percentage of eligibles.[2] It is important to define these terms. "Fee-for-service Medi-Cal eligibles" are synonymous with "fee-for service beneficiaries or enrollees." This term refers to people eligible for, and enrolled in, the Medi-Cal fee-for-service program, as opposed to enrolled in a Medi-Cal managed care plan. "Users" are synonymous with patients (i.e., fee-for-service beneficiaries that have used a home health service at least once during the year). "Annual expenditures" are total Medi-Cal fee-for-service payments to home health agency providers. "Units," as defined in the Review, are number of claims. Claims are synonymous with bills submitted by providers. As will be discussed below, claims are a meaningless measure of volume of service, since the number of services the provider chooses to include in one claim versus spreading them over several claims is arbitrary,

Based on the data in its Table 1, the Review alleges that a generally-increasing level of expenditures and increasing units per user are the result of the increase in services that home health agencies (HHAs)

[2] "Further Rate Review," p. 4.

provided to Medi-Cal beneficiaries. This allegation is not warranted for at least two reasons, and in fact the data show the opposite. First, using number of claims as service units is misleading, since a "claim" could include a single service, a large number of services, or anything in between. And second, it ignores that expenditures per beneficiary declined over this period.

The service units are defined as number of claims, which is an arbitrary measure of volume. All agencies do not bill in the same manner (i.e., some may submit a claim for each service, while others may submit a claim that bundles a number of services). A claim is a bill for services submitted to the Medi-Cal intermediary (the entity contracted to process claims). The number of services included in a claim is not set forth in statute or regulation; it is at the provider's discretion. Thus, a count of claims is a meaningless and irrelevant measure. Since payment rates have been frozen since 2000, it is likely that in the ensuing years an increasing number of agencies have been under pressure to improve cash flow. This suggests a trend toward more-frequent billing, and thus a decreasing tendency to bundle services into a single claim. The less aggregated the number of services per claim, the greater the number of claims per patient, which is not indicative of more services per patient, and could even mask fewer services per patient. The likelihood that services per claim have been dropping is illustrated in Table 1 below, which, based on the data from Table 1 in the Review, shows total expenditures, number of users and units (i.e., claims) per user. From this information I calculated expenditures per claim, in the far right column. As expected, the amount paid per claim has been dropping. The average payment per claim in 2005 was 13 percent less than in 2001. This trend is certainly consistent with a pattern of billing for fewer services per claim over time, and demonstrates that claims is an incorrect measure of volume of service provided.

TABLE 1
HOME HEALTH USERS, EXPENDITURES, UNITS AND EXPENDITURES PER UNIT
2001-2005

Year	Users	Annual Expenditures	Units per User	Total Units	Expenditures per Unit
2001	6,738	$147,014,000	2.26	15,228	$9,654
2002	6,465	$149,059,700	2.45	15,839	$9,411
2003	7,373	$157,454,000	2.50	18,433	$8,542
2004	7,158	$162,194,000	2.76	19,756	$8,210
2005	6,230	$161,395,000	3.10	19,313	$8,357

Source: Table 1, "Medi-Cal Review of Access to Home Health Agency Services for 2001-2005," page 4, Department of Health Care Services, March 2013.

Given constant payment rates (frozen since 2000) and the trend toward increasing annual aggregate expenditures (notwithstanding a downturn in 2005), the Review erroneously claims that there has been an increase in services provided. When viewed in terms of expenditures per Medi-Cal beneficiary, rather than a slight upward trend, there is in fact a steady downward trend over this four-year period. From 2001 to 2005, per-eligible expenditures dropped 9.4 percent. This is shown in Table 2 below, which is based solely on data provided in the Review. It clearly shows worsening access since 2001. The Review ignores this trend.

TABLE 2
HOME HEALTH AGENCY MEDI-CAL EXPENDITURES PER FEE-FOR-SERVICE BENEFICIARY
2001-2005

Year	FFS Medi-Cal Eligibles	HHA Expenditures	HHA Expenditures per Eligible
2001	2,705,826	$147,014,000	$54.33
2002	2,960,783	$149,059,700	$50.34
2003	3,150,971	$157,454,000	$49.97
2004	3,286,032	$162,194,000	$49.36
2005	3,278,666	$161,395,000	$49.23

Source: Table 1, "Medi-Cal Review of Access to Home Health Agency Services for 2001-2005," page 4, Department of Health Care Services, March 2013.

Table 1 in the Review also shows the number of users as a percentage of Medi-Cal eligibles. This ratio dropped 24 percent from 2001 to 2005 (from 0.25 percent to 0.19 percent); a significant downward trend over a four-year period. This 24 percent drop suggests that providers are being more and more restrictive in accepting Medi-Cal patients, and thus access has worsened over the period. The Review ignores this trend also, which is set forth in its Table 1. Not only does the Review dismiss this trend, but it but it draws an inaccurate comparison with the data in its 2008 Rate Review. In the current Review, it states: "The percentage of HHA users out of the Medi-Cal fee-for-service eligible population during 2001-2005 was favorable when compared to the percentages during the 1992-1997 period considered in the 1998 study, which determined there was sufficient access."[3] Table 4 in the 2008 Rate Review shows that from 1992 to 1997, users as a percentage of beneficiaries increased from 0.13 percent to 0.26 percent.[4] Yet in 2001, as shown in the current Review's Table 1, the percentage was 0.25 percent, and dropped to 0.19 percent by 2005. Thus, the percentage of HHA users out of the Medi-Cal fee-for-service eligible population during 2001-2005 was <u>not favorable</u> when compared to the percentages during the 1992-1997 period. Data from 2001 to 2005 show that access has worsened between 1997 and 2001, and that it worsened further between 2001 and 2005 – contrary to the Review's claim of "favorable."

Rather than demonstrating no decrease in access since 2001, the data contained in the Review's Table 1 show the opposite:

- Claims are an inappropriate and misleading measure of volume of service. Rather than supporting an allegation of no declines in access, the tendency of providers to bill for fewer services per claim over time (which is supported by my Table 1) is supportive of a finding of worsening access since 2001.

- The substantial (24 percent) drop in the ratio of users to eligible, and the further supports a finding of worsening access.

[3] Op. Cit., p. 10.
[4] "Medi-Cal Home Health Rate Review with Consideration of Efficiency, Economy, Quality of Care and Access," Department of Health Care Services, June 2008, Table 4, p. 11.

- Expenditures per eligible, calculated from the data in the Review's Table 1, decreased 9.4 percent from 2001 to 2005, further supporting a finding of worsening access.

- These three findings all point to worsening access since 2001. Thus, there is no basis to draw a conclusion of adequate access from the data presented in the Review's Table 1.

The Review provides speculative, anecdotal explanations for the drop in number of users. The explanations mainly involve observations and assertions that, over this time period, other programs that could serve as substitutes for home health services have expanded. The Review provides no data showing a shift away from home health to these specific alternative services, and offers no reasons why there would be such a shift, with one exception – the Home and Community Based Services (HCBS) waiver program. And even here, the Review's reasoning is inconsistent with available data. Even if alternative services are available, however, this does not indicate lack of an access problem to home health services if the beneficiary is entitled to such services and cannot get them.

- If a patient is unsuccessful in gaining access to home health services, but is able to obtain access to an alternative service, this does not suggest absence of an access problem. If a potential home-health patient is forced to choose a less appropriate alternative, this is indicative of inadequate access. For example, the Review suggests that adult day health care and pediatric day health care providers are alternatives to home health services.[5] If, however, home health services are preferred by the affected patients, their families and their physicians, and the alternative represents a hardship, being forced to use the alternative is indicative of inadequate access to home health services. The Review does not provide an analysis of the relationships between home health services and the various alternatives proposed (e.g., if and how they complement each other within a system of care, the frequency of use of alternatives when the patient is entitled to home health services which are not available).

- The Review cites increases in Adult Day Health Care (ADHC) enrollees, however, provides no evidence of any overlap between the ADHC population and the home health population. In the AHDC discussion, as well as discussions involving other programs that may be substitutes for home health agencies, the Review provides no data or analysis showing that patients chose to have ADHC services rather than home health services. And even if patients did receive services through ADHC rather than home health, it would reflect an access problem if they were forced to make a substitution of a less appropriate treatment modality because of a lack of available providers. The review provides at most, for some of the programs, incomplete data on numbers of users for a few of the years being examined. In any event, if beneficiaries use ADHC because of a lack of home health services, then an access problem exists.

- Since Medi-Cal pays for services for all the cited programs, the authors of the Review certainly had access to complete data on utilization from 2001 to 2005, yet chose to only provide incomplete fragments of such data.

[5] Op. cit., p. 6.

- In discussing the Home and Community Based Services (HCBS) waiver program, the Review suggests that inpatient care provided by skilled nursing facilities is also an alternative to home health, since federal law requires that the amount spent under the waiver not exceed what would be spent in an institutional setting such as a skilled nursing facility (i.e., "cost neutrality").[6] The Review neglects to present data, clearly in the Department's possession, on how this requirement has impacted use of home health services. According to data reported by skilled nursing facilities to the Office of Statewide Health Planning and Development, from 2001 to 2005 Medi-Cal payments per patient day increased 19 percent.[7] Thus, since 2001, it should have become easier to demonstrate a cost advantage for home health services versus the institutional alternative. Over the 2001-2005 period, the federal requirement regarding cost neutrality should have become less restrictive because of a 19-percent differential over what existed in 2001 in relative costs due to the home health rate freeze. This differential should have resulted in an increase in home health services rather than the decrease speculated in the Review.

In summarizing its assertion that from 2001 to 2005 Medi-Cal beneficiaries had sufficient access to home health services, the Review alleges that: "The fact that there were fewer 'users' during 2001-2005 compared to the 1992-1997 period considered in the earlier study had nothing to do with HHAs being unwilling to provide services based on the increased rates established in 2000. The fact that there were fewer HHA users in the fee for service system was related to several factors, including fewer fee-for-service eligible beneficiaries, an increase in alternative providers such as ADHDs and pediatric day health care providers, and changes under the HCBS waiver program."[8] (Emphasis added.)

- With respect to "fewer fee-for-service eligible beneficiaries," my Table 2 above shows that expenditures per fee-for-service beneficiary declined by 9.4 percent over the 2001-2005 period, and Table 1 in the Review shows a decrease in users per beneficiary over this time period.

- With respect to "an increase in alternative providers such as ADHDs and pediatric day health care providers, and changes under the HCBS waiver program," the Review provided no data analysis supporting its conclusion; data which are readily available to the Department. Lacking such an analysis, the only conclusion that can be drawn from the data presented is that access has worsened. Moreover, presence of alternatives does not negate lack of access to home health services if the latter is the preferred alternative from medical and patient-well-being perspectives, or if "choice" of an alternative is the result of lack of access to home health services.

- With respect to "changes in the HCBS waiver program," an approximate 19 percent increase in SNF rates from 2001 to 2005 should have led to an increase, not a decrease, in home health services under federal cost-neutrality requirements. The fact that services decreased over this period reinforces a finding of worsening access.

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[6] Op. Cit., p. 7.

[7] Long Term Care Financial Reports, Office of Statewide Health Planning and Development, facility fiscal periods ending during calendar years 2001 and 2005.

[8] "Further Rate Review," p. 8.

The Review asserts, in its explanation of its Table 2, that the number of providers signed up as Medi-Cal participants is indicative of access, when comparing HHAs available to Medi-Cal and Medicare beneficiaries, respectively.[9] A provider that signs up for Medi-Cal is under no obligation to accept a minimum number of Medi-Cal patients. Becoming a Medi-Cal provider requires little effort. The application requests only a few identification items and a notarized signature.[10] As I show below in Table 5, a large number of Medi-Cal-participating agencies provide minimal service to Medi-Cal beneficiaries.

Table 3 below provides counts of HHAs receiving Medi-Cal payments in 2001 through 2004. It also breaks out those with minimal participation (i.e., receiving less than $600 in a given year). These data are from Department publications.[11] The most recent report available on the Department's Web site is for 2004. Note the generally downward trend for all participating agencies, and the more pronounced downward trend for agencies receiving in excess of $600 in Medi-Cal payments. In 2004, the last year reported, 8.5 percent of agencies received less than $600 in Medi-Cal payments. The Medi-Cal HHA payment rate for skilled nursing is $74.86 per visit; $600 per year covers eight visits per year. Notwithstanding these data in Table 3, obtained from the Department's own publications, the Review stated, "The number of HHAs providing services to Medi-Cal beneficiaries increased between 2001 and 2005 ..."[12] This is clearly not so.

TABLE 3
NUMBER OF HOME HEALTH AGENCIES RECEIVING MEDI-CAL PAYMENTS
2001-2004

Calendar Year	Total Agencies	Receiving < $600 in Payments	**Receiving ≥ $600 in Payments**
2001	462	23	**439**
2002	464	37	**427**
2003	442	30	**412**
2004	435	37	**398**

Source: California's Medical Assistance Program: Annual Statistical Report, Calendar Years 2001-2004, Department of Health Care Services.

III. PROVIDER COMPARISON BETWEEN MEDI-CAL AND MEDICARE

The Review erroneously claims that access for Medi-Cal beneficiaries is at least as good as that for the Medicare population. However, the data relied upon in the Review show the opposite.

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[9] Op. cit., p. 10.
[10] "21Enrollment_DHCS9098."
[11] California's Medical Assistance Program: Annual Statistical Report, Calendar Years 2001-2004, Department of Health Care Services.

[12] "Further Rate Review," p. 8.

Table 2 in the Review is an attempt to justify the greater participation of HHAs in the Medicare program than in the Medi-Cal program as not being indicative of a Medi-Cal access problem.[13] The calculations involve comparing the numbers of providers filing Medicare Cost Reports with those having Medi-Care provider numbers and submitting Medi-Cal claims, and the number of Medicare enrollees and Medi-Cal enrollees in the Aged, Blind and Disabled (ABD) aid categories. The Review provided calculations of Medicare and Medi-Cal enrollees per respective provider. Its findings of a higher ratio of enrollees to providers for Medicare led to the conclusion that Medi-Cal access was at least as good as Medicare access.

Table 4 below shows the change in Medicare and Medi-Cal ABD enrollees and numbers of Medicare and Medi-Cal HHAs for 2001 and 2005. Note that from 2001 to 2005 Medicare enrollees increased 6.4 percent, while the number of participating agencies increased 26.4 percent. With respect to Medi-Cal, participating agencies increased 7.2 percent while Medi-Cal enrollees increased 16.7 percent. Thus, based on the Review's own data and criteria involving simple counts of agencies, Medicare access improved, while Medi-Cal access worsened. The number of Medi-Cal enrollees increased by over twice the percentage as participating agencies did, while Medicare enrollees increased by less than one-fourth the percentage that participating agencies did.

TABLE 4
CHANGE IN NUMBER OF MEDICARE ENROLLEES, MEDI-CAL AGED, BLIND AND DISABLED ENROLLEES AND NUMBER OF PARTICIPATING HOME HEALTH AGENCIES
2001-2005

Year	Medicare Enrollees	Medi-Cal ABD Enrollees	Medicare HHAs	Medi-Cal HHAs
2001	3,947,000	1,416,368	504	419
2005	4,200,640	1,652,657	637	449
Increase	253,640	236,289	133	30
% Increase	6.4%	16.7%	26.4%	7.2%

Source: "Medi-Cal Review of Access to Home Health Agency Services for 2001-2005," Table 2, page 9, Department of Health Care Services, March 2013.

Table 5 takes account of the level of activity on the part of the participating home health agencies by separating out those agencies with very low volume (i.e., less than 60 visits per year – slightly over one visit per week). The table shows that 69 percent of Medi-Cal-participating agencies provided 60 or more Medi-Cal visits in 2005, while 99 percent of Medicare-participating agencies had 60 or more Medicare visits. Thus, there was a far higher percentage of Medi-Cal agencies than Medicare agencies with very low program volume (i.e., 31 percent versus 1 percent). Moreover, the average Medi-Cal agency had 1,879 Medi-Cal visits, compared to the average Medicare agency, with 9,667 Medicare visits – a five-fold difference. While there was a five-fold difference in average visits per agency, there was only a 2.5 to one difference in Medicare to Medi-Cal enrollees in 2005 (from Table 4). These comparisons highlight the importance of accounting for volume when assessing the number of agencies available to Medi-Cal as an indicator of access.[14]

[13] Op. cit., p. 9.

[14] Note that the data source in Table 5 is the Office of Statewide Health Planning and Development, while that in Table 4 is the Department's records.

Notwithstanding data available in the Department's own publications, as well as publically-available data from its sister state agencies, the authors of the Review relied on simple counts of participating agencies in its unwarranted claim that no access problem exists.

TABLE 5
MEDI-CAL AND MEDICARE HOME HEALTH AGENCIES WITH GREATER THAN 0 AND GREATER THAN OR EQUAL TO 60 VISITS
2005

Medi-Cal Agencies	
> 0 Visits	520
≥ 60 Visits	360
Agencies ≥ 60 Visits Percent of Agencies > 0 Visits	69.2%
Average Medi-Cal Visits per Agency	1,879
Medicare Agencies	
> 0 Visits	681
≥ 60 Visits	676
Agencies ≥ 60 Visits Percent of Agencies > 0 Visits	99.3%
Average Medicare Visits per Agency	9,667

Source: Office of Statewide Health Planning and Development, Annual Utilization Report of Home Health Agencies, Calendar-Year 2005.

IV. CONCLUSION

The utilization data for 2001 to 2005 presented in the Review clearly point to an access problem, notwithstanding the Review's assertions to the contrary. When these data are supplemented by the few additional data items I included, the access problem identified by the Report's data becomes even more pronounced. Not only does the Review's data show worsening access from 2001 to 2005, but a later study by the Department shows a substantial worsening since 2005.[15] This 2011 Access Analysis' Table 13 shows a significant decline in utilization over the 2007-2009 period for all aid categories (including a 44 percent decline for blind and disabled children), a particularly vulnerable group.

- The Review's use of claims as the utilization measure is not appropriate, due to different billing practices among HHAs, and the likelihood that payment pressures are forcing agencies to bill more frequently and in more disaggregated units subsequent to the rate freeze commencing in 2000. Data provided in the Review confirm a trend in fewer services per claim since 2001 (as shown in my Table 1).

- The assertion that Medi-Cal HHA expenditures increased slightly over this period does not acknowledge that per-beneficiary expenditures (which the only relevant access measure based on expenditures) decreased, as shown in my Table 2.

[15] "Medi-Cal Fee-For-Service Access Analysis: Durable Medical Equipment, Clinical Laboratory, Emergency Medical Transportation, Non-Emergency Medical Transportation, Home Health & Dental Services," p 11, undated.

- The Report's anecdotal discussion of possible substitute services is both speculative and incomplete. It neglected to provide utilization data clearly available to the authors on these services. It failed to recognize that the availability of substitute services does not necessarily offset worsening access for home health services. The Review failed to provide an analysis of the relationships between home health services and the various alternatives proposed, and the extent to which patients entitled to home health services are forced into alternatives due to lack of access. Availability of alternative services is basically irrelevant. What is relevant is access to the services that are needed.

- The Review provides no data showing a shift away from home health to these specific alternative services, and offers no reasons why there would be such a shift, with one exception – the Home and Community Based Services (HCBS) waiver program. And even here, the Review's reasoning is inconsistent with available data.

- The ratio of users to beneficiaries declined over the 2001-2005 period (by 2005 this ratio was three-quarters of its 2001 level). This suggests that providers are being more and more restrictive in accepting Medi-Cal patients (i.e., fewer Medi-Cal patients are obtaining services from home health agencies); a demonstration of worsening access.

- Simple counts of participating agencies do not provide an indicator of access, since there is wide variation in Medi-Cal volume among these agencies, and many (31 percent in 2005) had only token Medi-Cal volume. Yet the Review relies on such simple counts in justifying the erroneous conclusion that there is no access problem.

- While the Review asserts Medi-Cal beneficiaries had better access to HHA services than California Medicare beneficiaries, it based this assertion on numbers of beneficiaries per participating agency, without taking into account the volume of services provided by the participating agencies. It also did not take proper account of changes in the numbers of beneficiaries and participating agencies in the two programs from 2001 to 2005. In both instances, the data point to less and worsening access for Medi-Cal relative to Medicare beneficiaries. The Review's claims based on counts of available agencies are based on an irrelevant measure, without taking into account whether the agencies discriminate by limiting services.

- Not only does the Review's data demonstrate an access problem, but the access problem has even worsened since 2005, as demonstrated in the Department's 2011 Access Analysis. Failure to acknowledge and address the worsening access problem in the last decade through rate increases, led to the even worse access problem found in the 2011 Access Analysis. The Department's 2008 Rate Review, which led to the Court Order mandating the current Review, should have identified a growing problem. Instead, the access problem was allowed to fester.

In addition to these deficiencies, the Review does not address the federal statutory requirements regarding access, which require comparisons of access between Medi-Cal and the general population, which logically would include analyses of Medi-Cal needs, and those of the general population for home health services, and the degree to which these needs have been met (e.g., length of time from request for service and provision of service, difficulty in placing patients and unmet needs). The Department has access to much of the necessary data involving Medi-Cal, which could be supplemented with surveys

based on samples of providers, addressing Medi-Cal and the general public. The Review's unfounded, implicit assumption that in the base period, 2001, Medi-Cal access was adequate was not based on consideration of Medi-Cal needs and those of the general public.

The Review's narrow approach, which ignores the requirements for the type of access study mandated by Section 1396a(a)(30)(A), nevertheless demonstrates worsening access since the last Medi-Cal payment rate increase for home health agencies in 2000. It is thus incumbent on the Department to consider the reasons for this access problem. Given that there has been a rate freeze since 2001, and that by 2005 the payment rates were far below costs, as reported in my response to the Department's 2008 Rate Review, the obvious cause of the access problem is low payment rates.[16] While the Appeal Court's decision does not mandate the consideration of provider costs, it does state that, "if the Department can show that Medi-Cal beneficiaries received quality care and had access to home health agency services equal to that of the general public, one could reasonably assume that the rates paid for such services were not too low."[17] (Emphasis added.)

The Review's data clearly did not show that "Medi-Cal beneficiaries ... had access to home health agency services equal to that of the general public." Thus one could not "reasonably assume that the rates paid for such services were not too low," and it is reasonable to expect the Department to investigate costs to determine if the access problem is due to rates being inadequate.

In my 2008 Report I presented data for 2005 in Table 4 on mean cost per visit, median cost per visit and the Medi-Cal rate for home health visits according to type of service.[18] The full report is attached as Exhibit B. That table is replicated below.

HOME HEALTH AGENCY COSTS PER VISIT AND MEDI-CAL RATES
2005

	Skilled Nursing	Home Health Aide	Occupational Therapy	Physical Therapy	Medical Social Services	Speech Therapy
Mean Cost per Visit	$159.10	$84.73	$177.93	$171.10	$231.48	$190.76
Median Cost per Visit	$141.43	$67.03	$151.90	$156.13	$194.26	$171.00
Medi-Cal Rate	$74.86	$45.75	$71.36	$68.84	$96.22	$78.43
Number of Agencies with Cost ≤ Rate	7	30	3	1	3	6
% of Agencies with Cost ≤ Rate	3.6%	15.9%	1.7%	0.5%	1.6%	3.7%
Total Number of Agencies Reporting	192	189	181	192	190	163

Source: Medicare cost report data, DHCS Attachment 10.

[16] Henry W. Zaretsky, "Report for Presentation at Department of Health Care Services Medi-Cal Home-Health Rate Hearing, August 8, 2008, p. 5.
[17] California Association for Health Services at Home et al., v. State Department of Health Care Services et al., Court of Appeal of the State of California Third Appellate District, p. 15, filed 3/26/12.
[18] Zaretsky, Ibid.

The data in this table are from Medicare Cost Reports provided by the Department for its 2008 Rate Hearing, and only include Medi-Cal participating agencies that submitted Medicare Cost Reports. For all but home-health-aide services, in 2005 Medi-Cal payment rates covered the costs of less than 4 percent of agencies. For most services the Medi-Cal rates were less than half the mean and the median.

Below-cost rates present a particular problem for home health agencies, where nearly all costs are variable (i.e., labor-related and travel costs to patients' homes). Thus, treating Medi-Cal patients, whose payments involve a substantial shortfall from variable costs, does not even enable an agency to spread its fixed costs over more patients. For other types of providers, whose costs are more weighted toward fixed costs; at least in the short run some may be able to accept below-cost payers and still recover some of their fixed costs. Given the combination of rates being significantly below costs on average, and virtually all costs being variable (i.e., directly tied to volume), home health agencies are particularly vulnerable financially unless they have a relatively small Medi-Cal patient load. And as the inflation-adjusted value of the frozen rates declines over time, so do the agencies' willingness to accept Medi-Cal patients. Below-cost rates present the provider with strong incentives to restrict services provided to Medi-Cal patients. And this is what the Review's data confirm – a worsening access problem.

April 15, 2013

Sacramento, California

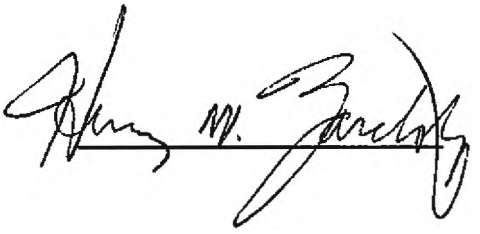

EXHIBIT A

HENRY W. ZARETSKY & Associates, Inc. www.henryzaretsky.com

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CURRICULUM VITAE

June 2011

HENRY W. ZARETSKY

Office Address:

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1900 Point West Way, Suite 111
Sacramento, CA 95815
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E-Mail: HZaretsky@aol.com

Marital Status:

Married, three children

Academic Degrees:

San Francisco State University	A.B. Economics
San Francisco State University	M.A. Economics
University of California, Davis	Ph.D. Economics

Major Fields of Study:

Health Economics
Econometrics
Applied Statistics
Labor Economics

Major Interests:

Strategic Planning
Economic Studies
Market Analysis
Litigation Support
Health Care Antitrust Analysis
Health Services Research
Public Policy

Professional Societies:

American Economic Association
American Statistical Association
Econometric Society
National Association for Business Economics

Committees:

Economic Literacy Council of California
Board of Governors, August, 1981 to September, 1986
American Health Planning Association
Board of Directors, June, 1979 to August, 1981
Planning Studies Advisory Committee, June 1979 to August, 1981
Advisory Committee for the "Integrated Data Demonstrations and the Health Planning Agencies," November, 1980 to August, 1981
Governor's Special Committee on Health Care Costs, September, 1978 to January, 1979 - Staff Coordinator
California Health Facilities Commission
Reports Committee, December, 1974 to June, 1977
Provider Liaison to Research Committee, September, 1977 to April, 1978
American Hospital Association
Special Committee on Medicare Payment Shortfalls, July, 1977 to April, 1978

Experience:

President, Henry W. Zaretsky & Associates, Inc., August, 1981 to Present.
Health care consulting firm established in August, 1981. Firm provides consulting services in the areas of strategic planning, HMO development, reimbursement, economic analysis, market studies, payment negotiations, litigation support and policy analysis.

Experience - Cont'd.

Adjunct Professor, University of Southern California Graduate Program in Health Services Administration, 2003 to Present. Teach course in health economics.

Director, Office of Statewide Health Planning and Development, State of California, April, 1978 to August 1981. Appointed by Governor Edmund G. Brown, Jr., as the first director of this new state department. Functions included administering California's health planning and certificate of need program; developing the State Health Plan, as a basis for State health policy; administering a state-guaranteed mortgage program for health facilities; approving architectural plans for health facilities; developing a biennial state health manpower plan; conducting pilot projects in the use of health personnel; administering programs to encourage availability of medical personnel in needed areas and specialties; and coordinating the health planning functions of all health-related departments in the Health and Welfare Agency. Administered fiscal 1980 budget of $13 million with 175 full-time equivalent personnel. Advised the Agency Secretary and the Governor on a wide variety of health policy issues.

Lecturer, School of Public Administration, University of Southern California, 1980 to 1981. Taught graduate course in operational planning for health.

Lecturer, School of Public Health, University of California at Los Angeles, 1979 to 1983. Co-taught a graduate course in regulation of health care.

Director of Research and Development, California Hospital Association, Sacramento, California, September, 1972 to April, 1978. Directed research program focused on economic regulation of health facilities and analysis of health policy, including development and implementation of a comprehensive health data system to meet the needs of regulatory programs and hospital management, development of alternative hospital reimbursement systems, refinement of health planning methods and analysis of legislative and policy proposals, using this data system and econometric and other statistical techniques. Provided staff support for the CHA Research and Development Committee, which in addition to advising on research issues, made policy recommendations to the Board of Trustees regarding economic regulation of health facilities. Served as liaison to the California Health Facilities Commission. Project Director on three federally funded projects dealing with economic regulation of health facilities and health data systems. Supervised four professional staff.

Lecturer, School of Public Health, University of California, Berkeley, 1978. Co-taught a graduate course in advanced financial management of health institutions.

Research Associate, American Medical Association, Chicago, Illinois, August, 1971 to August, 1972. Studied the economics of private medical practice through a federal contract. Using econometric methods, evaluated economies of scale in medical practice and the productivity of non-physician personnel.

Research Associate, Institute of Governmental Affairs, University of California, Davis, July, 1970 to August, 1971. Conducted dissertation research.

Experience - Cont'd.

Health Economist, Department of Community Health, School of Medicine, University of California, Davis, January, 1970 to August, 1971. Conducted a survey to assess the health status of Yolo County residents and their health habits, utilization and expenditure patterns. Designed sample, developed survey forms, and developed methods for analysis of data. Used data base in my dissertation research.

Consultant, California Optometric Association, 1970-71.

Consultant, California Association of Nursing Homes, 1970-71.

Teaching Assistant, Department of Economics, University of California, Davis, September, 1968 to December, 1969.

Statistical Methods Analyst, California Division of Highways, Sacramento, California, June, 1968 to September, 1968.

Research Assistant, Department of Economics, University of California, Davis, September, 1967 to June, 1968.

Regional Economist, Bay Area Transportation Study Commission, Berkeley, California, July, 1966 to August, 1967.

Teaching Assistant, Department of Economics, San Francisco State College, September, 1965 to June, 1966.

Research Assistant, Department of Economics, San Francisco State College, June, 1965 to September, 1965.

Federal Research Grants and Contracts:

Principal Investigator, "Development of California Excess Hospital Capacity Reduction Program," Health Care Financing Administration, Department of Health and Human Services, Grant Number 18-P-9752719-01, September, 1980 to August, 1981.

Project Director, "Prospective Incentive Payment Experiment," Social Security Administration, Department of Health, Education and Welfare, Contract Number 600-75-0165, April, 1975 to June, 1976.

Federal Research Grants and Contracts - Cont'd.

Project Director, "Hospital Regulatory Reporting System: A Demonstration," National Center for Health Services Research, Department of Health, Education and Welfare, Grant Number HS 01518-01, July, 1974 to September, 1975.

Project Director, "Hospital Effectiveness Demonstration Project," National Center for Health Services Research, Department of Health, Education and Welfare, Grant Number HS 01104-02, July, 1972 to November, 1974.

Publications and Papers:

"Comment on F.M. Scherer, 'How U.S. Antitrust Can Go Astray: The Brand Name Prescription Litigation,'" International Journal of the Economics of Business (November 1997), pp. 271-276.

"The Impact of Market Competition on Hospital Outpatient Payment Rates," California Healthcare Association, December, 1993. (H.W. Zaretsky and M.L. Vaida).

"Selective Contracting Program Too High a Price to Pay for Cost Savings," California Hospitals, Volume 5, No. 5 (September/October, 1991), pp. 24-28.

"Health Care Competition: The California Experience," presented at the Twenty-Ninth International Atlantic Economic Conference, Geneva, Switzerland, March 17-23, 1990. Abstract published in Atlantic Economic Journal, Volume XVIII, No. 3 (September, 1990), pp. 123-124.

"Review of The Social Transformation of American Medicine, by Paul Starr," Hospital Forum (September/October, 1983), pp. 44-45.

"Historical Analysis & Statewide Impact," Proceedings of the Seminar on Case Mix Method in Analysis of Teaching Hospital Costs, University of California Los Angeles Medical Center and School of Public Health (May 22, 1982), pp. 15-23.

"The Effects of Patient Mix and Service Mix on Hospital Costs and Productivity," in Issues in Health Economics, R.D. Luke and J.C. Bauer, ed. (Rockville: Aspen, 1982), pp. 245-264.

"Evolution and Prospects for State-HSA Health Expenditures Estimation in California," Journal of Health and Human Resources Administration (Summer, 1981), pp. 46-54. (H.W. Zaretsky and G.R. Cumming).

"A Proposal: Statewide Hospital Economic Control System," Hospital and Health Services Administration (Spring, 1981), pp. 70-94.

Publications and Papers - Cont'd.

"Response to: 'Delays in California CON Process Add $25 Million to Costs,'" Federation of American Hospitals Review (March/April, 1981), pp. 81-82.

"Capital Financing in the 1980s," Issues in Health Care, Vol. II, No. 1, 1981, pp. 58-59.

"Regulation vs. Competition," Hospital Forum (November/December, 1980), pp. 7-9.

"For Health Lawyers, Things Never Looked So Good: Response," American Journal of Law & Medicine (Winter, 1980), pp. 344-345.

"Analysis of Proposals to Limit Hospital Revenue," presented at the Second International Conference on Systems Science in Health Care, Montreal, Canada, July 14-17, 1980. Published in Systems Science in Health Care, C. Tilquin, ed. (Toronto: Pergamon Press, 1981), pp. 1317-1328.

"Health Planning: California's Director Views the Public Perspective," Hospital Forum (July/August, 1979), pp. 9-12.

"The Economics of Excess Hospital Capacity," presented at the Annual Conference of the Western Economic Association, Honolulu, Hawaii, June 20-26, 1978.

Hospital Fact Book, Sacramento: California Hospital Association, First Edition, 1976 and Second Edition, 1977 (H.W. Zaretsky and A.H. Morris).

"Prospective Reimbursement to Hospitals: A Proposal for a Statewide Regulatory Program," presented at the Annual Conference of the Western Economic Association, Anaheim, California, June 20-24, 1977.

"The Effects of Patient Mix and Service Mix on Hospital Costs and Productivity," Topics in Health Care Financing, 4, Aspen, 1977, pp. 63-82.

Final Report: Prospective Incentive Payment Experiment, Sacramento: California Hospital Association, 1976. (G.R. Cumming and H.W. Zaretsky). Contract Number 600-75-0165, Social Security Administration, Department of Health, Education, and Welfare. Published through NTIS.

"Estimation of Hospital Cost Functions, Controlling for Case Mix and Service Mix," presented at the annual Meeting of the Econometric Society, Dallas, Texas, December 28-30, 1975.

Hospital Regulatory Reporting System: A Demonstration, Volumes I and II, Springfield: National Technical Information Service (Order Number PB-253 071/5WW and PB-253 072/3WW), 1975. (G.R. Cumming, H.W. Zaretsky and A.H. Morris). Grant Number HS 01518-01, National Center for Health Services Research, Department of Health, Education, and Welfare.

Publications and Papers - Cont'd.

"Theory and History of Regulation," paper presented at the Annual Conference of the National Association of Regional Medical Programs, San Diego, California, September 23-25, 1975.

"The Demand for Health Care," paper presented at the Third World Congress of the Econometric Society, Toronto, Canada, August 20-25, 1975.

"Cost Functions for California Hospitals," paper presented at the Fiftieth Annual Conference of the Western Economic Association, San Diego, California, June 25-28, 1975.

Final Report: Hospital Effectiveness Demonstration Project, Sacramento: California Hospital Association, 1974. (G.R. Cumming and H.W. Zaretsky). Grant Number HS 01104-02, National Center for Health Services Research, Department of Health, Education, and Welfare.

Analysis of Hospital Costs Controlling for Service Mix and Case Mix Variation, Sacramento: California Hospital Association, 1974. Published through NTIS.

Development of a Financial Reporting System for Hospitals as a Basis for Regulation, Sacramento: California Hospital Association, 1974. Published through NTIS.

The Demand for Health Care: A Theoretical and Empirical Analysis, unpublished doctoral dissertation, University of California, Davis, 1974.

Development and Implementation of a Financial Reporting System for Hospitals, Sacramento: California Hospital Association, 1973.

Preliminary Analysis of the Productivity of Allied Health Personnel in Primary Medical Practice, American Medical Association, Chicago, Illinois, June, 1972. (B.H. Kehrer and H.W. Zaretsky).

"The Production of Health by a Rural Population," paper presented at the American Statistical Association Meetings, August 23-26, 1971, Fort Collins, Colorado. Published in Proceedings of the Social Statistics Section, American Statistical Association, 1971.

A Preliminary Report on the Yolo County Health Survey, Department of Community Health, School of Medicine, University of California, Davis, 1971. (N.O. Borhani, J.F. Kraus and H.W. Zaretsky).

"Simultaneous Estimation of an Industry Supply-Demand Relationship for Labor," paper presented at the Western Economic Association Meetings, August 21-22, Long Beach, California. Abstract in the Western Economic Journal, September, 1969.

Adjunct Professor Distinctive Service Award, University of Southern California State Capital Center, School of Policy, Planning and Development, 2007.

Discussant and chairman of various meetings of the Western Economic Association.

Made presentations before a wide variety of health professional groups.

Testified in front of a variety of legislative committees, regulatory bodies and federal and state courts.

EXHIBIT B

REPORT FOR PRESENTATION AT DEPARTMENT OF HEALTH CARE SERVICES MEDI-CAL HOME-HEALTH RATE HEARING

Henry W. Zaretsky, Ph.D.*

President, Henry W. Zaretsky & Associates, Inc.
Sacramento, California

August 8, 2008

PREPARED FOR CALIFORNIA ASSOCIATION FOR HEALTH SERVICES AT HOME

*Dr. Zaretsky's resume is provided as Exhibit A.

REPORT FOR PRESENTATION AT DEPARTMENT OF HEALTH CARE SERVICES MEDI-CAL HOME-HEALTH RATE HEARING

Henry W. Zaretsky, Ph.D.

August 8, 2008

This report provides an analysis of the "Medi-Cal Home Health Rate Review," prepared by the Department of Health Care Services (DHCS). This report addresses the discussion and conclusions in the DHCS "Rate Review" regarding the adequacy of Medi-Cal payments to home-health agencies in terms of efficiency, economy, quality of care and access. This report is divided into three sections – Access to Home-Health Services; Quality of Care; and Home-Health Agency Costs, Cost Increases and Medi-Cal Payment Rates. In each section, the DHCS "Rate Review" assertions are discussed, followed by my analysis. From this review and analysis, my conclusions are as follows:

(1) Access to home-health services has worsened since the last Medi-Cal payment increase in 2000, and does not match the levels available to the general population;

(2) In terms of quality of care, DHCS has not presented sufficient data to make any judgment;

(3) Since the last payment rate determination in 2000, on average, home-health agency costs have increased between 25 and 30 percent. For home-health visits, negligible percentages of agencies recover full costs, and payment rates are approximately half the median levels; and

(4) Notwithstanding DHCS' failure to conduct any (let alone annual) cost studies to support its rate-setting process, it has had Medicare Cost Report data available since at least 2000 upon which to base such studies.

I. ACCESS TO HOME-HEALTH SERVICES

The Department of Health Care Services (DHCS), in its June 2008 "Medi-Cal Home Health Rate Review," based on data showing increased Medi-Cal expenditures and numbers of users over the period 1992 to 1997, concludes that access to home-health services (HHA) is not rate driven.[1] This conclusion, based on 1992 to 1997 data, appears highly questionable; for example, the analysis fails to take into account that Medi-Cal rates for home-health services were increased in 1994, midway through the time period. In any event, using data from the current decade confirms an access problem. As shown in Table 1,

[1] "Medi-Cal Home Health Rate Review with Consideration of Efficiency, Economy, Quality of Care, and Access," Department of Health Care Services, June 2008, Table 4, page 11.

according to the Office of Statewide Health Planning and Development (OSHPD) Annual Utilization Report of Home Health Agencies, of 794 agencies reporting 60 or more total home-health visits in 2005, 276 (35 percent) had no Medi-Cal visits. Those with 60 or more visits totaled 360 – less than half the agencies. By contrast, 84 percent of agencies had 60 or more Medicare visits – nearly double the Medi-Cal participation rate. The limited Medi-Cal participation rate undoubtedly reflects low Medi-Cal payment rates.

TABLE 1
NUMBERS OF AGENCIES PARTICIPATING IN MEDI-CAL AND MEDICARE
AT VARIOUS LEVELS
2005

Visit Categories	Number of Agencies	Percent of Agencies
With ≥ 60 Total Visits*	794	100%
With > 0 Medi-Cal Visits	518	65%
With ≥ 60 Medi-Cal Visits	360	45%
With > 0 Medicare Visits	676	85%
With ≥ 60 Medicare Visits	664	84%

Source: Office of Statewide Health Planning and Development, Annual Utilization Report of Home Health Agencies, Calendar-Year 2005.

*A threshold of 60 total visits is used to prevent inclusion of agencies reporting for small portions of a year or other aberrant agencies.

In contrast to the previous decade, as shown in Table 2, Med-Cal expenditures on home-health services started to decline in 2005, and that decline continued in 2006. Indicative of the effect of payment rates on access is the particularly large percentage increase in expenditures from 2000 to 2001, immediately following the 2000 rate increase. Significant increases followed for another three years. This pattern suggests that after a point, access is reduced as the real value of Medi-Cal payment rates continues to decline, the further out in time from the last Medi-Cal payment increase in 2000.

TABLE 2
HOME-HEALTH MEDI-CAL FEE-FOR-SERVICE EXPENDITURES AND NUMBER OF CLAIMS.
2000-2006

Year	Expenditures	% Change	Claims	% Change
2000	$187,815,720		719,984	
2001	$199,499,332	6.2%	748,178	3.9%
2002	$205,722,309	3.1%	783,411	4.7%
2003	$216,024,710	5.0%	832,212	6.2%
2004	$228,405,911	5.7%	903,821	8.6%
2005	$217,126,681	-4.9%	835,317	-7.6%
2006	$205,827,197	-5.2%	808,889	-3.2%

Source: Medical Care Statistics Section, DHCS. Data are for dates of service during each calendar year. Home-health services are defined in terms of "provider type 14."

Expenditures declined 4.9 percent in 2005, and an additional 5.2 percent in 2006. Number of claims also declined – 7.6 percent in 2005 and 3.2 percent in 2006. As shown in Tables B1 and B2 in Exhibit B, there was a decline in expenditures for all major home health services commencing in 2005, following generally continuous growth between 2000 and 2004. Total expenditures in 2006 were 90 percent of those in 2004. At the same time, as shown in Table 3, the total number of Medi-Cal beneficiaries has remained roughly constant over this period. This pattern is clearly indicative of diminished access to home-health services for Medi-Cal beneficiaries.

TABLE 3
NUMBER OF MEDI-CAL BENEFICIARIES
2004-2006

Year	Monthly Average Enrollment
2004	6,530,060
2005	6,556,362
2006	6,520,310

Source: DHCS Medical Care Statistics Section Web site. Monthly averages are for calendar years.

It should be noted that the increases in expenditures and claims observed from 2000 to 2004 do not imply that Medi-Cal-beneficiary access to home-health services was, at that time, adequate or comparable to that available to the general public. On the contrary, as shown in Table 1, considerably fewer home-health agencies are available on a meaningful basis to Medi-Cal beneficiaries (i.e., agencies willing to accommodate more than token Medi-Cal volume of less than 60 visits annually) than to the Medicare population or the general public.

In its "Rate Review," DHCS also points to an increase in the number of Medi-Cal HHA providers from 2001 to 2005 to argue that access is sufficient.[2] These data, however, do not distinguish between levels of participation among agencies. As observed in Table 1 above, in 2005, 158 participating agencies had fewer than 60 Medi-Cal visits in that year, which could be considered only "token" participation.

DHCS also cites increasing numbers of Treatment Authorization Requests (TARs) and approvals as evidence that TAR processing is not inhibiting access.[3] I am not aware of allegations that the TAR process is inhibiting access.

SUMMARY OF ACCESS OBSERVATIONS

Contrary to the 1992-1997 data relied upon by DHCS to show there are no access problems, all the data presented here (for the current decade) point to access problems for Medi-Cal home-health patients. First, relatively few agencies have meaningful participation rates in Medi-Cal – only 45 percent of agencies have 60 or more Medi-Cal visits annually (slightly more than one visit per week). And 35 percent of agencies provide no service to Medi-Cal beneficiaries. Second, Medi-Cal expenditures for

[2] Op. cit., Table 7, page 14.

[3] Op. cit., Table 8, page 15.

home-health services have declined between 2004 and 2005, and 2005 and 2006, while the number of Medi-Cal beneficiaries has remained essentially constant. This implies the Medi-Cal visit rate per beneficiary has declined between 2004 and 2005, and between 2005 and 2006.

II. QUALITY OF CARE

DHCS's examination of quality of care relies solely upon data on complaints.[4] This is a meaningless exercise. First, DHCS lists numbers of complaints tracked by the Licensing and Certification Division from 2003 to 2005, showing an overall increase from 202 to 251. These complaints are not necessarily related to agencies serving Medi-Cal, or to Medi-Cal patients, or to the relative Medi-Cal patient load in each agency. There is no indication of the severity of the complaints, or what, if any, action was taken. Also, given that total home-health visits number in the millions, if there are quality problems, Licensing and Certification tracking of less than 300 complaints, is unlikely to identify them. Moreover, there is no indication that complaints are a significant quality indicator.

Second, DHCS lists complaints to the Board of Registered Nursing, which also are not restricted to Medi-Cal. Over the period 2001 to 2005, these complaints ranged from 13 to 16. Clearly, measuring quality of care involves considerably more than simply counting complaints, especially when such complaints cannot be associated with Medi-Cal-participating agencies. It is apparent that the complaint-tracking system is not equipped to distinguish the validity or severity of the reported complaints.

The DHCS "Rate Review" does not discuss the quality-of-care implications of continuity of care. In the context of home-health services, continuity of care involves the availability of direct care personnel (e.g., nurses and therapists) that are familiar with individual patients and their unique needs and problems. When access is restricted, there is likely to be less continuity of care, as a patient may be shuttled among various home-health agencies, or there may be high staff turnover rates within individual agencies. In these cases, quality of care may be compromised. The relationship between continuity of care and quality in the context of health care in general is well documented in the literature.[5]

Rather than relying solely on complaints data, which are meaningless, DHCS should have performed an appropriate assessment of quality of care. One component of such a study would involve examining the frequency and extent of Medi-Cal versus non-Medi-Cal home-health patients being cared for by multiple staff members in the same occupational classification.

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[4] Op. cit., pp. 7-10.

[5] See for example, J.W. Saultz and J. Lochner, "Interpersonal Continuity of Care and Care Outcomes, A Critical Review," Annals of Family Medicine, 3(2), March-April 2005, 159-166; and M.O. Cabana and S.H. Jee, "Does Continuity of Care Improve Patient Outcomes?", Journal of Family Practice, 53(12), December 2004, 974-980. For home-health care specifically, see J.B. Smith, "Competition and Continuity of Care in Home Health Nursing," Home Healthcare Nurse, 9(1), January-February, 1991, 9-13.

III. HOME HEALTH AGENCY COSTS, COST INCREASES AND MEDI-CAL PAYMENT RATES

Based on cost report data provided by DHCS (which only include Medi-Cal participating agencies that submit Medicare Cost Reports), for all but home-health-aide services, in 2005 Medi-Cal payment rates covered the costs of less than 4 percent of agencies (see Table 4). DHCS' methodology and assumptions for defining an efficient home-health agency are not set forth in its "Rate Review." The Medi-Cal rate for skilled nursing services covered the costs of only those agencies whose costs were less than 53 percent of the median; or 46 percent of the median in the case of speech therapy – amounts that are clearly inadequate under any definition of efficiency. By contrast, in setting Medi-Cal payment rates for skilled nursing facilities, DHCS has traditionally used the median.

TABLE 4
HOME HEALTH AGENCY COSTS PER VISIT AND MEDI-CAL RATES
2005

	SN	HHA	OT	PT	MSS	ST
Mean Cost per Visit	$159.10	$84.73	$177.93	$171.10	$231.48	$190.76
Median Cost per Visit	$141.43	$67.03	$151.90	$156.13	$194.26	$171.00
Medi-Cal Rate	$74.86	$45.75	$71.36	$68.84	$96.22	$78.43
Number of Agencies with Cost ≤ Rate	7	30	3	1	3	6
% of Agencies with Cost ≤ Rate	3.6%	15.9%	1.7%	0.5%	1.6%	3.7%
Total Number of Agencies Reporting	192	189	181	192	190	163

Source: Medicare cost report data, DHCS Attachment 10.

In updating Medicare payment rates on an annual basis, The Centers for Medicare and Medicaid Services (CMS) relies upon its market basket index, which measures the annual increase in input costs facing home-health agencies. Since the last Medi-Cal payment rate update in 2000, home-health agency costs, on a national basis, have increased 26 percent, according to the market basket (see Table 5). Between 2005 and 2007, they increased 7 percent; thus it is likely the negligible percentages of agencies that were able to recover their costs in 2005 further declined as of 2007.

TABLE 5
CMS PROSPECTIVE PAYMENT SYSTEM MARKET BASKET
FOR HOME HEALTH AGENCIES
2000-2007

Year*	Market Basket
2000	0.905
2001	0.941
2002	0.973
2003	1.004
2004	1.035
2005	1.067
2006	1.102
2007	1.139
% Increase 2000-07	25.9%
% Increase 2005-07	6.7%

Source: CMS Web site.
*Third quarter.

The 26-percent increase in input costs between 2000 and 2007 likely understates the cost increases incurred by California agencies for two reasons: (1) California's cost of living in general increased at a greater rate than the U.S. as a whole over this time period; and (2) California's nursing shortage, exacerbated by the acute-hospital nurse staffing ratios, implemented in 2004, most likely caused an increase in nursing wages beyond that experienced nationally. The market basket may also understate California cost increases because between 2000 and 2007, California's minimum wage increased 30 percent, while the national minimum wage increased only 5.6 percent.[6] While most home-health agency employees are paid above minimum wage, the market for relatively low-wage agency employees may be affected by minimum wage increases.

The California All-Items Consumer Price Index increased 24.4 percent between 2000 and 2007, while the national index increased 20.4 percent, reflecting a higher inflation rate in California.[7] Thus, California's overall inflation rate was 20 percent higher than the national rate over this period. Applying this differential to the market basket increase suggests home health agency costs in California increased over 30 percent since 2000.

It is likely, however, that home-health agency costs in California increased at an even greater rate due to the nurse shortage exacerbated by the hospital nurse staffing ratios.[8] As hospitals are forced to bid up

[6] California Department of Industrial Relations Web site, and Economic Policy Institute Web site.

[7] California Department of Finance Web site.

[8] On the nurse shortage in California and the impact of the staffing ratios, see, for example: "Governor Announces $90 million California Nurse Education Initiative," Governor's Office, April 15, 2005; "California's Nursing Shortage Crisis will Vary by Region, UCSF Report Shows," UCSF News Office, August 22, 2006; "California Forecasts Nursing

. wages to attract more nursing personnel (both RNs and LVNs) to comply with the new staffing ratios, home-health agencies have to compete for nurses in these same "sellers' markets."

. Table 6 shows annual percentage increases in average hourly wages for registered nurses (RNs) and licensed vocational nurses (LVNs) in California from 2000 to 2007. Note the particularly large increases in 2004, 2005 and 2006 for both occupations, which most likely reflect the impact of the hospital nurse staffing ratios. The 11.5 percent increase and 9.1 percent increase for RNs and LVNs, respectively, from 2005 to 2007 is indicative of cost pressures subsequent to the nursing visits cost data presented in Table 4. Since the last Medi-Cal rate increase in 2000, by 2007 nursing wages alone increased from 29 percent (for LVNs), to 40 percent (for RNs). Nationally, over the same period, LVN wages increased 28 percent, and RN wages 35 percent, further suggesting that the Market Basket data presented in Table 5 understates the increases in input prices faced by California home-health agencies.[9]

TABLE 6
ANNUAL RATES OF INCREASE
HOURLY WAGES
REGISTERED NURSES AND LICENSED VOCATIONAL NURSES
CALIFORNIA
2000-2007

Year	RN	LVN
2000	3.8%	1.9%
2001	3.2%	1.5%
2002	4.2%	2.8%
2003	3.2%	2.5%
2004	7.4%	5.0%
2005	5.3%	5.2%
2006	6.7%	5.1%
2007	4.5%	3.8%
2007/2000	39.9%	29.0%
2005/2000	25.5%	18.3%
2007/2005	11.5%	9.1%

Source: "State Occupational Employment and Wage Estimates," Bureau of Labor Statistics Web site.

The major substitutes for home health services are: (1) added days in an acute hospital; and (2) skilled nursing facilities (both freestanding and hospital distinct-part).. To the extent provision of home-health services is discouraged through inadequate payment rates, Medi-Cal patients are forced to use, and the

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Shortage of 12,000 by 2014," American Society of Registered Nurses, June 16, 2007; and "Hospitals Expect Hiring Spree to Meet Nurse Staffing Ratios," Silicon Valley/San Jose Business Journal, March 11, 2005.

[9] "State Occupational Employment and Wage Estimates," Bureau of Labor Statistics Web site.

program to pay for, these more expensive substitute services, or go without services altogether. Medi-Cal has established provisions to update rates for these substitute services.

Inpatient acute-care hospitals are paid by Medi-Cal according to either negotiated rates with the California Medical Assistance Commission (CMAC), or are reimbursed based on costs, with some limits. In both cases, there are provisions for periodic increases, either driven by CMAC negotiations or incurred costs.

Hospital distinct-part nursing facilities are provided an annual update based on cost data projected to the rate year, equal to the lesser of projected costs or median projected costs for facilities with Medi-Cal patient days accounting for more than 20 percent of total patient days.

Until 2005, freestanding skilled nursing facilities were provided periodic Medi-Cal rate updates based on median calculations of projected costs. They are currently paid based on facility-specific costs.

Among these post-acute services, only home-health is not provided a process for periodically updating Medi-Cal payment rates. And ironically, home-health services are in general the least costly of these post-acute services.

In authorizing home-health services under the Home and Community Based Services (HCBS) Waiver or services related to Early Periodic Screening Diagnosis and Treatment (EPSDT), which combined account for approximately 85 percent of all Medi-Cal home-health expenditures, a demonstration must be made on a case-by-case basis that the services to be authorized are not more costly than skilled nursing facility services ("cost neutrality"). If these less costly services are not available due to agencies restricting their Medi-Cal participation, the alternative is more costly inpatient services.

The non-waiver, non-EPSDT services are primarily home visits by nurses; home-health aides; physical, occupational and speech therapists; and medical social workers. They are of short duration, and don't approach the costs involved in inpatient care.

Thus, the Medi-Cal program is protected by authorization criteria based on cost neutrality. In addition, at least one recent study provides empirical evidence that state HCBS programs may prevent or delay nursing home admission for those with limited family care-giving resources.[10] Also, The National Association for Home Care & Hospice tabulates comparisons between monthly costs in hospitals and home-health agencies for seven conditions that can be treated in both settings, showing home-care

[10] N. Muramatsu, H. Yin, R.T. Campbell, R.L. Hoyem, M.A. Jacob, and C.O. Ross, "Risk of Nursing Home Admission Among Older Americans: Does States' Spending on Home-and Community-Based Services Matter?", The Journals of Gerontology, 62B(3), May 2007, pp. 169-178.

savings for each.[11] Thus, restricting access to home health services does not appear to be a cost-effective strategy.

SUMMARY OF COST AND RATE FINDINGS

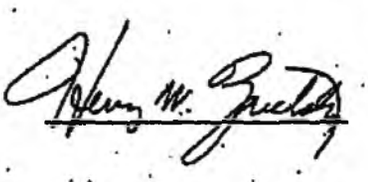
Home-health-agency costs have increased substantially since the last Medi-Cal rate increase in 2000. This increase reflects general inflation, as well as added inflation in wages for nurses reflecting the nurse shortage exacerbated by hospital nurse staffing ratios implemented in 2004. In 2005 Medi-Cal rates for home visit services allowed a negligible number of agencies to recover their costs, and were set at approximately one-half median costs.

The DHCS strategy of freezing home-health agency rates at their 2000 levels flies in the face of its service authorization criteria under the HCBS Waiver and for ESDT services, which require cost neutrality between home health services and alternative post-acute services; generally more-costly inpatient skilled nursing facilities. Through effectively cutting real (i.e., inflation-adjusted) rates by 3 percent to 4 percent annually since 2000, DHCS has caused access to these less costly home health services to decline. At the same time, the providers of the more costly substitute post-acute services (primarily freestanding and hospital distinct-part skilled nursing facilities) are afforded periodic rate updates.

By producing Attachment 10 to its "Medi-Cal Home Health Rate Review," DHCS has shown that it has had available cost data on home health agencies since at least 2000 that could have formed the basis for annual rate studies. Yet it has failed to conduct any such studies.

August 8, 2008

Sacramento, California



[11] "Basic Statistics About Home Care, Updated 2008," The National Association for Home Care and Hospice, 2008, page 19.

EXHIBIT B

TABLE B1
MEDI-CAL EXPENDITURES ON MAJOR HOME HEALTH SERVICES
2000-2006

Procedure Code	Procedure Name	2000	2001	2002	2003	2004	2005	2006
ZS832	EPSDT REGISTERED NURSE	$ 4,260,568	$ 5,069,721	$ 5,956,640	$ 6,190,921	$ 6,148,629	$ 5,444,238	$ 5,641,905
ZS834	EPSDT LVN	$ 105,476,081	$ 116,045,575	$ 120,734,751	$ 127,906,765	$ 137,299,865	$ 133,304,088	$ 127,430,775
ZS836	EPSDT RN SUPERVISION	$ 2,157,151	$ 2,203,739	$ 2,146,470	$ 2,376,758	$ 2,451,172	$ 2,063,591	$ 2,000,287
ZS838	EPSDT HOME HEALTH AIDE	$ 1,447,673	$ 1,558,600	$ 1,938,580	$ 2,881,241	$ 3,682,035	$ 3,511,238	$ 3,441,029
Z6704	LVN 1 HR	$ 898,046	$ 1,393,953	$ 2,308,440	$ 8,749,825	$ 9,639,838	$ 9,235,509	$ 7,826,438
Z6718	LVN HOURLY	$ 43,142,104	$ 41,969,287	$ 40,177,589	$ 35,012,367	$ 35,256,266	$ 33,739,852	$ 29,180,038
Z6720	HOME HEALTH AIDE HOURLY	$ 5,445,317	$ 5,299,567	$ 5,201,449	$ 5,066,895	$ 5,193,624	$ 4,984,519	$ 3,796,640
Z6900	SKILLED NURSING VISIT	$ 14,941,973	$ 15,048,004	$ 15,035,490	$ 15,556,922	$ 15,622,079	$ 12,174,481	$ 11,403,732
Z6904	PHYSICIAL THERAPY VISIT	$ 1,504,158	$ 1,589,747	$ 1,588,860	$ 1,680,211	$ 1,923,715	$ 1,642,058	$ 1,594,702
Z6914	CASE EVALUATION & INITIAL PLAN	$ 858,455	$ 863,298	$ 837,320	$ 849,690	$ 881,287	$ 756,915	$ 676,513
	SUBTOTAL	$ 180,131,525	$ 191,041,492	$ 196,025,589	$ 206,271,596	$ 218,098,510	$ 206,856,389	$ 192,992,059
	ALL SERVICES	$ 187,815,720	$ 199,499,332	$ 205,722,309	$ 216,024,710	$ 228,405,911	$ 217,126,681	$ 205,827,197

Source: Medical Care Statistics Section, DHCS. Data are for dates of service during each calendar year. Home-health services are defined in terms of "provider type 14."

TABLE B2
MEDI-CAL EXPENDITURES ON MAJOR HOME HEALTH SERVICES
ANNUAL RATES OF CHANGE
2000-2006

Procedure Code	Procedure Name	2001	2002	2003	2004	2005	2006
Z5832	EPSDT REGISTERED NURSE	19.0%	17.5%	3.9%	-0.7%	-11.5%	3.6%
Z5834	EPSDT LVN	10.0%	4.0%	5.9%	7.3%	-2.9%	-4.4%
Z5836	EPSDT RN SUPERVISION	2.2%	-2.6%	10.7%	3.1%	-15.8%	-3.1%
Z5838	EPSDT HOME HEALTH AIDE	7.7%	24.4%	48.6%	27.8%	-4.6%	-2.0%
Z6704	LVN 1 HR	55.2%	65.6%	279.0%	10.2%	-4.2%	-15.3%
Z6718	LVN HOURLY	-2.7%	-4.3%	-12.9%	0.7%	-4.3%	-13.5%
Z6720	HOME HEALTH AIDE HOURLY	-2.7%	-1.9%	-2.6%	2.5%	-4.0%	-23.8%
Z6900	SKILLED NURSING VISIT	0.7%	-0.1%	3.5%	0.4%	-22.1%	-6.3%
Z6904	PHYSICIAL THERAPY VISIT	5.7%	6.2%	-0.5%	14.5%	-14.6%	-2.9%
Z6914	CASE EVALUATION & INITIAL PLAN	0.6%	-3.0%	1.5%	3.7%	-14.1%	-10.6%
	SUBTOTAL	6.1%	2.6%	5.2%	5.7%	-5.2%	-6.7%
	ALL SERVICES	6.2%	3.1%	5.0%	5.7%	-4.9%	-5.2%

Source: Medical Care Statistics Section, DHCS. Data are for dates of service during each calendar year. Home-health services are defined in terms of "provider type 14."