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April 8, 2013
John Mendoza, Acting Division Chief
Fee-For-Service Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4600
Sacramento, CA 95814

Re: Maxim Healthcare Services – Comments on the Preliminary Report on "Medi-Cal Further Rate Review of Access to Home Health Agency Services for 2001-2005"

Dear Mr. Mendoza:

Maxim Healthcare Services, Inc. provides home healthcare, medical staffing, and wellness services across the U.S., and we appreciate the opportunity to offer our comments on the Preliminary Report. While perhaps not directly related to the issues from the 2001-2005 timeframe addressed in the Preliminary Report, we want to emphasize the direct correlation that we see between reimbursement rates and access. Our review of the data shows a clear connection in more recent years between reimbursement rates and the number of agencies providing hourly nursing support services to Medi-Cal beneficiaries. Following the 2008 rate cuts, there are fewer agencies providing services to a larger patient population. We believe that future reimbursement rate decisions must take that correlation into account.

In 2012, Maxim had more than 325 employees in the State of California, and more than 12,500 caregivers, including private duty nurses. As a dependable homecare provider for more than 20 years, in 2012 we served more than 12,000 patients here, of whom more than half (approximately 6,600) were pediatric. We currently provide private duty nursing services (PDN) to Medi-Cal beneficiaries, primarily medically fragile pediatric patients. Almost half of our total 2012 revenues in the state came from Medi-Cal, so PDN reimbursement rates are critical to our ability to continue to provide these services to this fragile population.

The Preliminary Report notes a "steady growth of 7% in the number of HHA providers participating in the Medi-Cal program during 2001-2005" (p. 2). That historical growth stands in stark contrast to more recent data, which shows a decline following a 2008 cut in reimbursement rates. In our review of data previously supplied by the State, in the first quarter of 2011, only 117 home care agencies (HHAs) delivered hourly nursing support services to Medi-Cal beneficiaries. This reflected a 14% reduction in the number of HHAs providing this service compared to Q1 2008, when California implemented provider rate reductions. At the same time, the number of hourly nursing support Medi-Cal beneficiaries serviced by HHAs grew from 2895 in the first quarter of 2008 to 3224 in the first quarter of 2011. In other words, fewer agencies are providing services to a greater patient census as smaller providers cannot afford to continue providing services under current reimbursement.

The California Labor and Workforce Development Agency has found that in the first quarter of 2011, the hourly mean wage for a home health care RN was $38.67 and for a LVN was $25.24. With current Medi-Cal reimbursement at $40.16 for RN and $29.12 for LVN the remaining participating home health providers are operating on very thin margins – if they are making any profit at all – and any future cuts in reimbursement rates would only exacerbate the problems that HHAs are already facing.

Most of the beneficiaries receiving hourly nursing support services are children with multiple disabilities that are at the highest risk of institutionalization. As there are virtually no sub-acute facilities that can service these children, they will likely require Acute Hospitalization. The failure to adequately manage chronic conditions can lead to deterioration in health status. This already vulnerable group of Medi-Cal beneficiaries should not have to face disruptions in care with likelihood that their healthcare needs will go unmet.

Furthermore, when these patients lose access to the in-home benefit, the alternative care setting available to these patients, frequently a pediatric hospital, can be significantly more expensive to the state or other payors. Last month, AARP released a study that underscores the cost differential between the two settings, surveying 38 state-specific studies that had been conducted over the last year, including in California. ("State Studies Find Home and Community-Based Services to Be Cost Effective," available at http://www.aarp.org/health/medicare-insurance/info-03-2013/state-studies-find-hcbs-to-be-cost-effective-AARP-ppi-ltc.html). The following statement was included in the summary of the findings:

> The studies consistently showed lower average costs per individual for HCBS compared to institutional care. In California, for example, spending on nursing home care per person was three times higher than for HCBS [home and community based services] —$32,406 for nursing facility care versus $9,129 for HCBS in 2008.

Therefore, we believe that this area is ripe for payment reform models that encourage lower cost settings. For example, rather than simply being paid for our time in the home, Maxim would like to explore how we could partner with the state in a way that ties our reimbursement to our ability to keep patients out of the more expensive care settings. We think the first step in this direction would be a claims data analysis that looks at the total cost of care for these patients across the various institutional and in home care settings. That information could be used to inform a discussion around new payment models. Maxim would be very interested in partnering with the state on this type of analysis.

Thank you for your consideration of our comments. Please feel free to contact me if you have any questions.

Very truly yours,

Jarrod DePriest
Vice President of Operations
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