January 22, 2015

The Honorable Joseph R. Pitts

Chairman

Health Subcommittee

Committee on Energy and Commerce

2125 Rayburn House Office Building

Washington, DC 20515

The Honorable Gene Green

Ranking Member

Health Subcommittee

Committee on Energy and Commerce

2322A Rayburn House Office Building

Washington, DC 20515

Dear Chairman Pitts and Ranking Member Green:

The National Association for Home Care & Hospice (NAHC) is the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies, and public corporations. NAHC has worked constructively and productively with Congress and the regulators for three decades, offering useful solutions to strengthen the home health and hospice programs.

NAHC applauds the Committee for moving quickly in the new Congress to address the flawed Sustainable Growth Rate (SGR) under Medicare. We appreciate the opportunity to weigh in on the issues being raised and thank you in advance for your consideration of these comments. As the Committee and Leadership continue working towards a permanent solution, we understand that finding a way to pay for any solution presents significant policy questions. Numerous options have been presented by stakeholders, policymakers, and thought leaders. Balancing the impact of these proposals with the need for permanent reform is an unenviable task. However, for the reasons outlined below, we strongly urge the Committee to oppose any proposal to implement a Medicare copayment for home health services.

**Background**

Congress eliminated the home health copayment in 1972 because it was shown to deter Medicare beneficiaries from accessing home health care and instead created an incentive for individuals to seek more expensive institutional care. Recently, however, some policymakers have suggested adding copayments for Medicare home health services. This is a short-sighted approach to reducing the deficit by limiting the growth of Medicare home health expenditures. Moreover, home health services already have the highest cost-sharing in Medicare. On a daily basis, millions of spouses, family, friends, and community groups contribute the equivalent of billions of dollars worth of care and support to keep their loved ones at home. Further, care in the home means that the Medicare beneficiary provides all the financial support in terms of room and board that are otherwise paid for by Medicare and Medicaid in an institutional setting.

**Impact of a Home Health Copayment**

Home health copayments would create a significant barrier to access for those in need of home care, lead to increased use of more costly and often less preferred institutional care—undoing progress made to date to reverse the trend of unnecessary hospitalizations and nursing home stays—and increase Medicare spending overall. Numerous studies have concluded that a copayment can discourage patients from receiving necessary and beneficial care, with a disproportionate impact falling on the oldest, sickest, and poorest Medicare beneficiaries. Deterring patients from accessing necessary care can result in worse health conditions and lead to higher costs for the Medicare program. Avalere projects a home health copayment could *increase* Medicare hospital inpatient spending by $6-13 billion over ten years.

Beneficiaries would not only suffer in terms of health status, but would experience financial hardship if faced with a copayment. In 2010, half of Medicare beneficiaries lived on incomes below $22,000 per year (under 200% of poverty). These low-income beneficiaries are not necessarily protected against Medicare cost sharing by Medicaid; eligibility for assistance with Medicare cost sharing under the Medicaid Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100% of poverty, subject to a very restrictive asset test. To the extent that state Medicaid programs are responsible for QMB beneficiaries, states will be saddled with an unfunded mandate.

Finally, copayments are billed as an attempt to fix that which isn’t broken, namely the rate of home health utilization. However, beneficiaries do not “order” home health care for themselves. Services are ordered by a physician who must certify they are medically necessary, that beneficiaries are homebound and meet other stringent clinical standards. The Medicare home health benefit comprises a smaller portion of Medicare spending and serves a smaller proportion of Medicare beneficiaries today than in 1997.

A home health copayment would also directly conflict with Congress’ goal of modernizing Medicare. As noted above, a copayment will drive beneficiaries into costly institutional settings. Similarly, chronic disease is a major driver of health care costs and community-based chronic care management has long been provided effectively by home health agencies. A system that shifts patients from inpatient services and institutional care to home and community-based settings provides the best chance at extending the fiscal viability of the Medicare program while providing high-quality, clinically appropriate services. A home health copayment would frustrate the underpinnings of this model and increase Medicare costs.

A home health copay would inevitably result in home health providers having to incur significant bad debt, which they are not in a position to absorb. Home health providers have experienced multiple payment cuts in recent years, jeopardizing the availability of this critical benefit. The Medicare home care benefit was $17 billion in 2009, but has been and will be cut by a projected $110 billion over the succeeding ten years. As a result of these cuts, over 56 percent of all Medicare participating agencies are projected to be under water in 2017. Without sufficient availability of home health providers, the important work done to date on modernizing the Medicare benefit would be undone.

**Conclusion**

We appreciate your consideration of these comments. If home care is to be part of the solution to inefficient health care spending, the benefit must be both accessible to patients and available as part of modernizing Medicare program design. For these reasons, NAHC respectfully urges the Committee to reject any proposals to offset an SGR fix by implementing a home health copayment. If you have any questions or need any further information, please do not hesitate to contact us.

Sincerely,

Val J. Halamandaris

President

National Association for Home Care & Hospice