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Chairman of the Board

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
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Val J. Halamandaris, JD
President

October 20, 2011

The Honorable Patty Murray
The Honorable Jeb Hensarling

Co-Chairs, Joint Select Committee on Deficit Reduction

The Honorable Xavier Becerra
The Honorable Dave Camp
The Honorable James E. Clyburn
The Honorable John Kerry
The Honorable Jon Kyl
The Honorable Rob Portman
The Honorable Pat Toomey
The Honorable Fred Upton
The Honorable Chris Van Hollen

Members, Joint Select Committee on Deficit Reduction The Honorable Max Baucus

Dear Co-Chairs and Members:

On behalf of home health and hospice providers and the millions of patients they serve, the National Association for Home Care & Hospice urges you to ensure that any Medicare or Medicaid provisions included in a deficit reduction package strengthen home health and hospice programs and protect beneficiaries. It is well documented that home health and hospice are both a seniors-preferred and cost-effective setting for clinical treatment and palliative care.

Of particular concern are proposals that would impose additional costs on seniors who seek to access home health and hospice services through new copays and deductibles. As you know, there once was a home health copayment and deductible—until Congress wisely repealed the copay in 1972 and the deductible in 1980 due to the burden placed on seniors, collection costs, and the services shifted to more costly settings.

Seniors receiving home health and hospice are disproportionately poor and sick. Nearly 4-out-

of-5 non dual eligible home health beneficiaries have no secondary Medigap coverage and, consequently, would be personally responsible for the full copayment. More than half of these beneficiaries have incomes below \$21,780 per year. In fact, these seniors experience a 25 percent greater rate of poverty than the typical Medicare beneficiary. These beneficiaries are three times more likely to have Activities of Daily Living (ADL) limitations. Due to these factors, copayments would be a regressive “sick tax” and devastating to seniors.

Home health and hospice copayments would shift seniors to more costly settings. The Medicare Payment Advisory Commission (MedPAC) has cautioned that “A disadvantage of requiring beneficiary cost sharing for post-hospital episodes of home health care is that it could encourage beneficiaries to use higher cost post-acute care settings, such as skilled nursing facilities or inpatient rehabilitation facilities.” By incentivizing patients to seek care in more costly settings, a copayment will be counterproductive – increasing the use of more expensive care.

Home health and hospice copayments would increase Medicare and Medicaid costs. The research firm Avalere Health estimates that the copayment-caused shift of patients to hospitals, nursing facilities and other settings could increase Medicare costs billions of dollars over the next 10 years. Avalere also projects that a home health copayment will drive up Medicaid costs because States bear a portion of the copayment for dual-eligible individuals and due to patients shifting to more costly settings. The Congressional Budget Office (CBO) has confirmed this problematic effect, noting in its analysis that a home health copayment “would result in increased spending by Medicaid.” A hospice copayment would likely have a similar result.

We are troubled that some are suggesting copayments or other fees on seniors are necessary to make sure they have “skin in the game.” Seniors already have extraordinary skin in the game: they have paid taxes, built our nation, and defended its freedom. Moreover, according to the AARP Public Policy Institute, Medicare beneficiaries spend an average of \$4,394, or 37 percent of the individual beneficiary’s income, on health care costs. The oldest and poorest beneficiaries spend more than half their incomes on health care services. Patients going on service for home health and hospice must pay a 20 percent copay and the Part B deductible to retain the services of a physician who can order the home health or hospice plan of care and provide care plan oversight. Those coming from the hospital will have incurred a Part A deductible of over \$1100. The estimated economic value of unpaid contributions by family caregivers to those being cared for at home is approximately \$450 billion a year.

Copayments as a means of reducing utilization would be particularly inappropriate. Since 1997, the average number of home health visits provided over a 60-day episode under Medicare has dropped from 36 to 18. Spending on a per-patient basis is no greater today than in 1997. Adjusted for inflation, Medicare spends billions less on home health today than in 1997 and serves fewer beneficiaries. The home health benefit has dropped from 8.7 percent of the Medicare program to less than 4 percent. Hospice represents only 2 percent of Medicare spending; CMS Administrators have repeatedly called for greater use of hospice, not less.

Home health payments were cut by nearly \$40 billion last year, hospice by nearly \$8 billion.

CMS regulations will cut billions more from both home health and hospice. Additional across-the-board home health and hospice cuts would entirely disrupt the home health and hospice community. Already over 53 percent of home health agencies and 76 percent of hospices are projected to be paid less by Medicare than their costs in 2012. Deeper payment cuts will directly impact access to care for Medicare beneficiaries in need of home health and hospice services.


Because of budgetary pressures, states are struggling to preserve their Medicaid home and community-based care programs. The states have been seeking to achieve savings by rebalancing Medicaid long term care programs with more cost-effective home care and less institutionalized care. A reduction in the federal contribution to Medicaid could seriously undermine access to home care and hospice and set back these rebalancing efforts.

Home health agencies and hospices are ideally positioned to help provide jobs if more cuts can be avoided and the existing infrastructure remains intact. Four of the 10 most needed jobs in America—nurses, physical therapists, home care aides and personal care assistants—are central to the home health and hospice mission. With the use of exciting new job creating telehomecare technologies, these home health and hospice professionals can provide better care to more people at lower cost.

Allowing nurse practitioners (NP) and physician assistants (PA) to sign home health plans of care (S.227/H.R.2267) would save \$300 million over 10 years, according to a study by Dobson DaVanzo & Associates. NPs and PAs can certify eligibility for costly Medicare skilled nursing facility care but not for more cost effective home health care. Unnecessary hospitalizations and nursing home stays could be avoided by correcting this anomaly. Please include this provision in your deficit reduction package.

We can achieve sustainable Medicare and Medicaid savings, improve quality outcomes, and strengthen program integrity, but doing so requires thoughtful reforms – not the imposition of a new copayment or deductible on beneficiaries or across the board payment cuts on the care they receive. Thank you for your efforts to uphold our commitment to America's seniors and the millions of beneficiaries who depend on home health care and hospice.

Sincerely,



Andrea L. Devoti, MSN, MBA, RN
Chairman of the Board