Partnership for Quality Home Healthcare

VIA E-MAIL: entitlementreform@mail.house.gov

August 16, 2013

The Honorable Dave Camp
Chairman
Ways and Means Committee
1102 Longworth House Office Building
United States House of Representatives
Washington, D.C. 20515

The Honorable Sander Levin
Ranking Member
Ways and Means Committee
1106 Longworth House Office Building
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Camp and Ranking Member Levin:

The Partnership for Quality Home Healthcare is grateful for this opportunity to provide our views to the House Ways and Means Committee regarding Medicare beneficiary cost-sharing. Established in 2010 to support government officials in ensuring access to skilled home healthcare services, the Partnership is a coalition representing nearly 2,000 community- and hospital-based home healthcare agencies across the United States. Partnership members are dedicated to developing innovative reforms to improve the quality, efficiency, and integrity of home healthcare for homebound seniors and disabled Americans.

The Partnership commends the Committee for its long history of ensuring Medicare beneficiaries' access to the high-quality, cost-effective services they need and deserve. We also appreciate the Committee's sensitivity to the many complex issues relating to beneficiary cost burdens. As a result, we would like to comment on the following issues, which we believe to be especially important to the nearly 3.5 million homebound senior citizens and disabled Americans who rely upon the Medicare home health benefit:

- The President's Budget provision relating to the re-imposition of a Medicare home health copayment was proffered as part of a "grand bargain," rather than as a stand-alone change.
- A home health copayment was initially included in the Medicare program but was repealed by Congress in 1972 due to its unanticipated impact on vulnerable beneficiaries and program costs.
- Medicare home health beneficiaries are poorer, older and sicker than the Medicare population as whole, already bear considerable costs, and would be seriously impacted by a copayment.
- Re-imposition of the home health copayment will increase Medicare spending as well as State Medicaid costs, due to copayment coverage and the shift of patients to more costly settings.
- Governors and policy experts have expressed concern with the re-imposition of a home health copayment, and surveys of seniors find high levels of opposition to such a policy change.
- Re-imposition of a copayment would impact home health providers, who are struggling with unprecedented cuts, and could therefore jeopardize their sector-leading job creation.
- Targeted program integrity reform is a proven and preferred way to achieving sustainable program savings without harming vulnerable beneficiaries or increasing State and Federal costs.

Fiscal Year 2014 (FY14) President's Budget Provisions

The Committee's Summary of "The President's and Other Bipartisan Proposals to Reform Medicare: Modernizing Beneficiary Cost-Sharing" states, in part:

> *To address concerns with the sustainability of the Medicare trust funds, the Obama Administration has identified several key policies to modernize cost-sharing within the Medicare program. In the President's FY14 budget, the Administration focused on three key cost-sharing policies: (1) increasing income-related premiums for Medicare Parts B & D; (2) increasing the annual Medicare Part B deductible; and (3) establishing a home health co-pay.*

With respect to a home health copayment, the Summary further states:

> *In his FY14 budget, President Obama proposed to institute a $100 home health co-pay per home health episode, for new beneficiaries (policy would begin in 2017). The proposal would exempt the co-pay if the home health episode was directly preceded by a hospital or inpatient post-acute stay. The FY14 President's budget estimated that this policy would save $730 million over 10 years. The Congressional Budget Office estimated that this policy would save $700 million over 10 years.*

As has been noted by Members of the Committee, the President's budget provision relating to the re-imposition of a Medicare home health copayment was proffered in the spirit of a "grand bargain" on federal government finances, which included a broad array of spending and revenue changes. As a result, a home health copayment has not been understood as a stand-alone policy recommendation.

Issues relating to Re-Imposition of a Medicare Home Health Copayment

As the Committee is aware, the Medicare program originally included a copayment for home health services. Congress wisely repealed it in 1972, however, because it led to patients being served in more expensive facility-based settings and was found to create "a financial burden to many elderly persons living on marginal incomes."[1]

Just as in the early 1970s, Medicare home health beneficiaries are predominately of low-income and therefore unable to afford the cost of out-of-pocket copayments. According to analyses conducted by Avalere Health, increased-out-of-pocket costs would put significant financial strain on the Medicare home health population because it is poorer, older and sicker than the Medicare beneficiary population as a whole. For example, while nearly 40 percent of all Medicare beneficiaries without supplemental coverage have annual incomes below 200 percent of the Federal Poverty Limit (FPL), nearly 75 percent of all Medicare home health beneficiaries do so. Further, this population already bears considerable costs simply by residing in their homes, rather than in institutional settings, where taxpayers bear the room, board, laundry, utility and other costs borne by patients receiving healthcare services at home. With low-income beneficiaries' average annual cost of living at an estimated $15,648, a substantial share of their income, after Medicare Part B premium costs and living expenses, would therefore be consumed by higher out-of-pocket fees.[2]

[1] Congressional Record, United States Senate; October 5, 1972

[2] Avalere analysis of the 2010 Bureau of Labor Statistics Consumer Expenditure Survey for all households with at least one individual age 65 or older and annual income below 200% of the Federal Poverty Limit.

It is for these reasons that leading experts across the healthcare policy spectrum have expressed concern about the unintended consequences of a home health copayment. For example, former Congressional Budget Office Director Douglas Holtz-Eakin and *Forbes* contributor Robert Book recently wrote, "Medicare home health copays were eliminated in 1972 for just this reason – the increased hospital spending more than offset the government's savings on home health, and beneficiaries' health status was worse as well." Meanwhile, a report by the bipartisan Economic Policy Institute (EPI) found that a large portion of 'economically vulnerable' elderly Americans would be significantly impacted by entitlement changes such as the imposition of higher out-of-pocket costs.

Of significance, the low income of the Medicare home health beneficiary population is seen as a key reason why re-imposition of a home health copayment could lead to higher program costs. In order to avoid the higher out-of-pocket cost that would result from a re-imposed copayment, many low-income patients would forgo physician-prescribed home healthcare services. This, in turn, would cause health problems that could have been cost-effectively addressed in the home setting to instead worsen, leading to the delivery of treatment in institutional settings, which costs significantly more than do home-based clinical services. Indeed, a *New England Journal of Medicine* study found that copayments resulted in more annual hospital admissions, longer hospital stays, an increase in hospitalizations, and an overall cost that exceeded the copayment's savings.[3] Similarly, Avalere Health has determined that a home health copayment could lead to a $16.7 billion net increase in Medicare spending.[4]

Medicare beneficiaries are cognizant of these issues and are no more supportive of the re-imposition of higher costs now than when the home health copayment was repealed 40 years ago. A recent survey by Public Policy Polling of more than 1,100 American seniors who are registered voters found that:

- 74 percent disapprove of making seniors pay higher fees as a means to cut Medicare spending.
- 86 percent agree that increased out-of-pocket Medicare costs will strain low-income seniors.
- 82 percent would be less likely to support lawmakers who increase seniors' out-of-pocket costs.

Patient and senior groups also oppose re-imposing a home health copayment because it would place additional burdens on vulnerable patients while driving up overall Medicare costs. AARP, the nation's largest seniors organization, states that "requiring people who are prescribed home health services to pay copays would do nothing to reduce Medicare costs. More likely, it would increase costs because people who can't afford the copays could end up returning to the hospital." Similarly, the Center for Medicare Advocacy and the Medicare Rights Center point out that, "While increased cost-sharing poses significant financial risks for beneficiaries, particularly for those living on low- and moderate-incomes, it is also shown to limit access to necessary health care services.…Imposing such co-pays would have a staggering impact on individuals with long-term and chronic conditions, who, under the President's proposal, would essentially incur $600 in new out-of-pocket costs annually. Additionally, adding copayments to the home health benefit would likely lead to higher hospitalizations (and thus higher costs) as a result of beneficiaries forgoing needed care when they cannot afford the co-payments."

State Governors – Republicans and Democrats alike – also appear to be aware of the risks associated with re-imposition of a home health copayment. Due to the Medicare home health beneficiary population's generally low income, a home health copayment would impose higher costs on States, as patients shift to more expensive settings and because their Medicaid programs would have to cover the cost of the copayment for dual-eligibles and Qualified Medicare Beneficiaries (QMBs).

[3] Trivedi, Amal N., Husein Moloo and Vincent Mor. "Increased Ambulatory Care Copayments and Increased Hospitalization among the Elderly." *New England Journal of Medicine* 362 (2010): 320-328.
[4] Avalere Health. Potential Impact of a Home Health Copayment on Other Medicare Spending. July 2011.

In a July 2011 letter sent to Congress, Georgia Governor Nathan Deal wrote that "a copayment requirement would only serve to shift thousands of low-income seniors out of home-based care into much more costly nursing homes and impose billions of dollars in additional Medicaid costs onto the states." In a letter to the White House, Maryland Governor Martin O'Malley expressed a similar sentiment, stating "imposition of a home healthcare copayment could seriously impact frail seniors and actually result in increased Medicare and Medicaid costs." These letters are also attached to this letter.

Indeed, re-imposition of a home health copay would come at a time when State Medicaid programs are increasing the use of home-based care over more costly alternatives. States and the Centers for Medicare and Medicaid Services ("CMS") are reported as shifting Medicaid spending away from costly settings and towards home and community-based care. This trend has been underway for some time, as evidenced by such leading initiatives as Ohio's PASSPORT Program. As Governor John Kasich described it, "In the past if somebody wanted to stay in their home, there were limited opportunities for them to do it. That day is gone. I can't think of anything more important to a senior than to be able to stay in their home with assistance rather than being put in a facility that they're not comfortable with."

Re-imposition of a home health copayment could negatively impact access to and the outcomes of taxpayer-funded healthcare services, as well. For example, physicians and skilled home healthcare providers are often successful in preventing costly hospital admissions through the delivery of services within the home and community. However, re-imposition of a cost that could prevent many beneficiaries from receiving such care would limit physicians' ability to reduce beneficiary readmissions.

Such a path is directionally opposite to the one taken by leaders in home-based care, such as the U.S. Department of Veterans Affairs ("VA") which has achieved extraordinary outcomes, savings, and patient satisfaction in its Home-Based Primary Care (HBPC) program. Recognizing that home-based care meets veterans' clinical while preventing costly institutional care, the VA ***eliminated*** a home care-related copay. The VA states that "Data have shown that expanded use of technology in the home enables patients with chronic health conditions, such as diabetes, chronic heart failure and hypertension, to live independently, actively engage in managing their health, and prevents avoidable hospitalization of patients who otherwise may need long-term institutional care." As Secretary Eric Shinseki noted, "Eliminating the copayment for this service will remove an unnecessary financial burden for Veterans."

Another important factor to be considered is the impact that re-imposition of home health copayment would have on the nation's economic recovery, as well. As illustrated by a series of data points, the home health sector is a significant engine of new job creation, due to the growth of America's senior population, its preference for home-based care, and payers' focus on cost-effective home-based care:

- According to the U.S. Bureau of Labor Statistics (BLS) July 2013 jobs report, the home healthcare sector created more new jobs (3,900) last month than any other healthcare field.
- Home healthcare jobs that were created in July account for nearly two-thirds of all new jobs created in the ambulatory health care services sector, allowing the overall healthcare sector to post positive job growth of 2,500. Without the significant increase in home health employment, the overall healthcare sector would have experienced a net loss of nearly 1,500 jobs.
- An analysis by Avalere Health finds that home healthcare jobs are expected to grow 5.5 times faster than all other non-farm industries for the remainder of the decade[5], unless funding reductions or policy changes that destabilize the home health sector are allowed to take effect.

[5] Avalere Health. Home Health Chartbook (2013): Economic contribution of home health agencies, 2011.

These data are worthy of consideration due to the anticipated impact of a copayment on the home healthcare sector. Due to their low income, many beneficiaries will be unable to pay the share of costs that a copayment would shift to them. Indeed, Medicare provides bad debt reimbursement precisely because of this phenomenon – *except to home health providers*. As a result, unpaid home health copayments will translate into unrecovered losses for home health providers, which will exacerbate the operating pressures they are already experiencing due to unprecedented Medicare funding cuts. Due to these factors, the home health sector's continued creation of jobs as part of the nation's economic recovery would be significantly jeopardized by re-imposition of the home health copayment.

Similarly, we wish to express our concerns with respect to estimated budgetary savings. According to the "Savings/Cost Estimates" grid made available by the Committee, the three policy changes on which the Committee is seeking comment would generate a total of $60.3 billion over 10 years, of which the home health copayment would generate $700 million. On its face, this may be viewed by some as inconsequential; however, the impact of a home health copayment will be far greater, due to its economic impact beyond the current 10-year window as well as its anticipated impact on homebound seniors and disabled Americans, on job creation, and on overall State and Federal costs.

For all of these reasons, we respectfully submit that re-imposition of a home health copayment would not serve the objective of "Modernizing Beneficiary Cost-Sharing" and would instead drag the Medicare program back to a policy that was found to be flawed and was repealed more than four decades ago.

Before closing, we would like to take this opportunity to also comment on the following excerpt from the Committee's Fact Sheet:

> *"Home health care is liable to abuse…and some cost-sharing is appropriate. We need to discourage people from using home health care that they don't really need." (Bipartisan Policy Commission testimony, May 21, 2013)*

Holtz-Eakin and Book addressed this perspective in their *Forbes* article:

> *Another justification cited for the change is the high rate of suspected fraudulent billing for home health care in certain geographic regions – regions which have levels of spending far out of proportion to the number of Medicare beneficiaries, even after accounting for their health status. But this raises a more fundamental question of priorities. Before using a co-pay to attempt [t]o discriminate among the many uses of home health services, it makes more sense to undertake anti-fraud, program integrity efforts to eliminate the bad actors….[A] co-payment is not an anti-fraud measure – quite the contrary, a co-payment would reduce legitimate use of home health care without affecting the level of fraud at all.*

As described in more detail below, we urge consideration of targeted program integrity reforms in lieu of beneficiary costs as a proven means for achieving cost savings and preventing abusive behavior without burdening vulnerable beneficiaries.

Targeted Program Integrity Reform

We wish to commend the Committee on its strong commitment to strengthening Medicare program integrity. This is an objective that the Partnership believes should be the overarching priority when any Medicare program change is contemplated. Although progress has been made in combatting fraud and abuse, much more work is required so that every beneficiary and taxpayer can be confident that the program they depend on and fund is secure.

The task of eradicating fraud and abuse from the home healthcare sector is aided by considerable evidence that the problem is largely isolated in defined pockets of the country. Indeed, federal data pinpoints where healthcare fraud and abuse is occurring. For example, the Medicare Payment Advisory Commission ("MedPAC") regularly identifies the 25 counties – out of the nation's 3,143 counties and county-equivalents – where abusive episode billing practices and excessive Medicare utilization occur. Further, data show that nearly 90 percent of all improper payments for home healthcare services are occurring in a small number of counties in just five states.

As a result of these data, we firmly believe policy makers should undertake targeted action to address fraud and abuse. Towards this end, home health leaders developed the Skilled Home Healthcare Integrity and Program Savings (SHHIPS) Act, which is designed to be as targeted as is the problem. As detailed in the letter we submitted to the Senate Finance Committee on June 27, 2012 and summarized in the table below, SHHIPS includes reforms that would prevent the payment of aberrant claims before they are made, improve claims review processes, and strengthen conditions of participation standards.

SHHIPS Reform Proposals

Program Integrity Reforms to Protect Beneficiaries and Prevent Fraud and Abuse	• **Prevent entry of individuals with criminal backgrounds:** Require criminal background checks for all employees with direct patient contact or access to patient records. • **Verify competency through improved standards:** Require background screening of owners and managing employees. • **Enforce provider integrity:** Require providers to have a compliance and ethics program to prevent and detect criminal violations. • **Ensure operational capacity to serve beneficiaries:** Require all new providers entering the market to secure a $100,000 surety bond. • **Temporary entry limitations to prevent excess growth:** Suspend issuance of new provider numbers in over-saturated counties.
Payment Integrity Reforms to Ensure Accuracy, Efficiency and Value	• **Prevent payment of aberrant claims:** Limit reimbursement of episodes to an aggregate annual per-provider average based on beneficiary location and establish a minimum annual low-utilization payment adjustment claim rate. • **Ensure accuracy of all claims:** Establish a uniform process to verify the validity of all claims prior to their payment.
Quality Outcomes Improvement	• **Improve care planning for Medicare skilled home healthcare services:** Permit non-physician providers, operating a physician's direct supervision, to complete initial patient assessments and coverage certifications.

SHHIPS reform proposals build on a successful precedent that was proposed by the home health community and went into effect January 1, 2010. To prevent the payment of aberrant claims, the community proposed a 10 percent limit on Medicare outlier claims. This proposal was adopted as part of the Affordable Care Act (ACA) and is estimated to have saved $853 million in 2010 alone and to be on track to deliver $11 billion in total savings over 10 years. Just as important, by preventing aberrant claims from being paid in the first place, this reform successfully replaced the troubled "pay and chase" model (for outlier claims) with a simple and logical "aberrant payment prevention" mechanism.

The utility of targeted program integrity reform was illustrated just last month when CMS announced it had "identified areas that stood as significant outliers compared to other comparable counties in the U.S." and would be implementing targeted moratoria as a result. The Partnership commended CMS for this important step, noting that "Targeted reforms are needed to strengthen the Medicare program, protect patients and defend taxpayers from fraudulent activities, which we believe is a better approach to Medicare reform than deep funding cuts and the re-imposition of a home health copay."

In addition to these reasons, we urge consideration of targeted program integrity reform due to the breadth of support that exists for it. The *Fight Fraud First!* Coalition is an important example: a collaborative effort on behalf of seniors, persons with disabilities, military veterans, and other concerned citizens, *Fight Fraud First!* members include AARP, Easter Seals, the National Grange, National Hispanic Coalition on Aging, and the Veterans Health Council, among other leading organizations. The Coalition advocates for the elimination of waste, fraud and abuse as a means to reduce federal costs and protect vulnerable beneficiaries, rather than the imposition of across-the-board cuts or the re-imposition of a home health copayment.

Of note, the *Fight Fraud First!* Coalition sent letter to Speaker John Boehner and Minority Leader Nancy Pelosi in December 2012, in which the Coalition urged "Instead of advancing across-the-board Medicare cuts or increasing out-of-pocket costs for America's seniors, lawmakers should advance targeted solutions to prevent improper and fraudulent payments before they occur."

Similarly, a recent survey by Public Policy Polling of more than 1,100 American seniors who are registered voters found that the vast majority of them think Congress should prioritize program integrity reform over Medicare cuts and beneficiary cost-sharing burdens. Key findings of the poll include:

- 93 percent of seniors surveyed think Congress should advance reforms to stop Medicare fraud instead of cutting Medicare funding or charging seniors higher costs.
- 77 percent of seniors approve of Congress doing all it can to combat Medicare fraud as a means to reduce federal spending.

In light of the proven utility of targeted program integrity reform and the breadth of its support, we therefore respectfully urge its consideration in place of the re-imposition of the flawed and repealed home health copayment.

Conclusion

On behalf of the Partnership for Quality Home Healthcare, thank you for your consideration of our perspectives on the many complex issues relating to the re-imposition of a home health copayment. We hope this response is of value to you in your important work and stand ready to serve as a resource in any way needed.

Sincerely,

Eric S. Berger
CEO, Partnership for Quality Home Healthcare

Letter from Governor Nathan Deal to Speaker John Boehner:

STATE OF GEORGIA
OFFICE OF THE GOVERNOR
ATLANTA 30334-0900

Nathan Deal
GOVERNOR

July 7, 2011

The Honorable John A. Boehner
Speaker
H-232 The Capitol
Washington, DC 20515

Dear Speaker Boehner,

As you consider legislation to address the federal debt ceiling and our nation's looming debt crisis, I would like to respectfully request your support in opposing a copayment requirement for Medicare and Medicaid-covered home healthcare services. Through my personal experience as a caregiver for my mother and my wife Sandra's parents, as the former chairman and ranking member of the Subcommittee on Health, and as governor for the State of Georgia, I am confident such a copayment requirement would only serve to shift thousands of low-income seniors out of home-based care into much more costly nursing homes and impose billions of dollars in additional Medicaid costs onto the states.

When I was the chairman of the Subcommittee on Health in the 109th Congress, you and I worked closely together to craft legislation that reduced our federal deficit by over $100 billion. While working on the *Deficit Reduction Act of 2005*, one of the CBO-recommended savings options we carefully considered was imposing a copayment requirement on home healthcare services. However, we rejected this flawed proposal because we knew imposing a copayment on home-based care would provide a strong financial incentive for low-income families to shift their loved ones into institutions for their long-term care. Since most seniors prefer to receive care in their own home and institutional-based care imposes significantly greater costs on the taxpayers, we focused instead on ways to facilitate and incentivize home-based care through provisions such as the Medicaid state plan option for home and community based support services and the *Money Follows the Person Rebalancing Demonstration Program*. These have been successfully implemented in our home states of Georgia and Ohio. We further reduced taxpayer-funded long-term care spending by creating new tools to allow states to reduce the prevalence of Medicaid fraud and focus their limited Medicaid funds on individuals who are actually eligible for these taxpayer-funded benefits.

With the forthcoming debt ceiling debate, I believe my former colleagues in Congress have the same opportunity to reduce the federal deficit the right way – by reducing the prevalence of fraud in the Medicare and Medicaid programs, not by imposing burdensome copayment requirements on innocent seniors. I understand the home healthcare community has stepped forward with a thoughtful and comprehensive proposal, the *Skilled Home Health Integrity and Program Savings (SHHIPS) Act*, which would strengthen the integrity of the home health benefit with meaningful – and, in some cases, unprecedented – measures. This bold reform plan deserves your attention because it will establish much-needed fraud and abuse-fighting mechanisms and achieve substantial scorable savings. Indeed, former CBO Director Douglas Holtz-Eakin has analyzed these measures and determined they would save in excess of $20 billion over the next 10 years. I respectfully urge your consideration of this bold reform plan. It is a far better solution than home healthcare copayments and cuts, it achieves sustainable savings, does not further burden state Medicaid programs, and it will erect strong barriers to the type of activity that has plagued patients and taxpayers for far too long.

As always, I appreciate your consideration of this request, and I appreciate your continued service to our nation and the people of Georgia. If I can ever be of assistance to you, please do not hesitate to contact me.

Respectfully,

Nathan Deal

Nathan Deal
Governor

Letter from Governor Martin O'Malley to Gene B. Sperling:

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

MARTIN O'MALLEY
GOVERNOR

STATE HOUSE
100 STATE Circle
ANNAPOLIS, MARYLAND 21401-1925
(410) 974-3901
(TOLL FREE) 1-800-811-8336

TTY USERS CALL VIA MD RELAY

July 13, 2011

Gene B. Sperling
Assistant to the President for Economic Policy and Director, National Economic Council
The White House
1600 Pennsylvania Avenue
2nd Floor, West Wing
Washington, DC 20500

Dear Mr. Sperling:

This letter serves as a follow up to my letter to you dated July 8, 2011, with accompanying white paper, laying out a proposal for your ongoing debt reduction negotiations that can provide cost savings in Medicaid and Medicare that can be scored by CBO (attached for reference). I urge that any Medicare provisions included in a budget deal strengthen both the Medicare and Medicaid programs and protect their beneficiaries. In particular, I wish to express my concern that the imposition of a home healthcare copayment could seriously impact frail seniors and actually result in increased Medicare and Medicaid costs.

If patients cannot afford home health care because of a new copayment, those patients may need to stay in the hospital or nursing home -- settings that cost far more than his or her home and which makes an individual who does not need to be there susceptible to additional complications. New fees for home healthcare in the Medicare program can also drive Medicaid costs, which would just push the budgetary hot potato down the line.

It would be more beneficial for us to align incentives and look to save both the states and the federal government through better coordination and more effective care. Referring back to the proposal that I sent you, there are considerable savings available through a coordinated program for "dual eligibles" and enhanced protections against fraud and abuse. Experts in Maryland are willing to provide additional details of such solutions.

Thank you for your understanding of this issue and for your efforts on behalf of the millions of Americans who rely on Medicare and Medicaid.

Sincerely,

Governor

cc: Valerie Jarrett
The Honorable Kathleen Sebelius, Department of Health and Human Services