

THE CONNECTICUT ASSOCIATION
for *Home Care, Inc*

July 31, 2003

The Honorable Christopher Shays
1126 Longworth Building
Washington, DC 20515

Dear Representative Shays,

On June 27, 2003, your office issued a statement about the H.R. 1 (Medicare Modernization and Prescription Drug Act) which stated, among other things, *“I also believe anything free, even health care, is over utilized. I support the House proposal to add a small co-payment to home health care.... This way, seniors have a greater incentive to get care because they need it, not just because it is offered.”* This statement mirrored comments that you made to members of the Connecticut Association for Home Care and me when we met with you on April 8, 2003 in Washington, DC.

Although your concern about over-utilization of health care may be well founded, there are a number of reasons why the logic of co-payments is particularly inapplicable to home health care.

There is no evidence of over-utilization. The attached chart, from the Medicare Payment Advisory Commission (MedPAC), clearly demonstrates that utilization dropped sharply after the implementation of a new “interim payment system” in 1998 and has remained flat since the adoption of the prospective payment system in 2000. The number of Medicare beneficiaries receiving home health care has dropped by 1.3 million in the last five years.

The new Medicare home health payment system minimizes any incentives for over-utilization. As we explained in our meeting with you, the new payment system pays home care agencies a flat fee for each 60-day “episode” of care, irrespective of how many visits the agency performs in that time period:

- Two-thirds of Medicare home health users only have a single 60-day “episode” of care. Nationally, the average number of visits provided over a 60-day episode has dropped from 36 to 20 (yet outcomes have remained the same or improved). Clearly, home health agencies are efficiently providing care.

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- Those beneficiaries that have multiple 60-day episodes of care are generally chronically ill and poor – hardly ideal candidates for imposition of a co-payment. The new co-payment could force these frail, lower income beneficiaries to spend-down onto Medicaid more quickly, causing more expenditure by Medicaid.

To the extent that a co-payment actually further reduced home health utilization, then we should be concerned about being “penny-wise and pound-foolish.”

According to the June 2002 MedPAC report, there have been recent substantial recent declines in the use of home health care, accompanying increases in use of more expensive skilled nursing facilities (SNFs), and substitution of SNFs for home health services following hospital discharges. A co-payment could exacerbate this trend – a bad idea. For similar reasons, there is a growing bipartisan consensus for eliminating coinsurance for preventive benefits.

The logistics of a home health co-payment are a nightmare. Nurses and home care aides might be placed in the position of having to collect co-payments, a task for which they are unsuited. Collecting co-payments in a person’s home is not like a hospital or physician’s office where clerical staff can handle billing and collection. In addition, unlike hospitals, there is no provision for bad debt from uncollected co-payments currently built into the base payment for home health care.

Congress wisely eliminated the Medicare home health co-payment 30 years ago for many of same reasons that it should not be resurrected now. Moreover, reinstating the co-payment today would directly conflict with the goal of modernizing the Medicare program and is not necessary given the realities of the new payment system for home health care.

When we met with you in April, you stated that you “did not want to become a victim of your own ideology” and promised to review the issue. We hope that you reconsider your position on a home health co-payment in light of the foregoing information. We look forward to continuing to work with you on these important issues and we have appreciated your open mind in the past. If you any questions, I can be contacted at (203) 265-9931. Thank you.

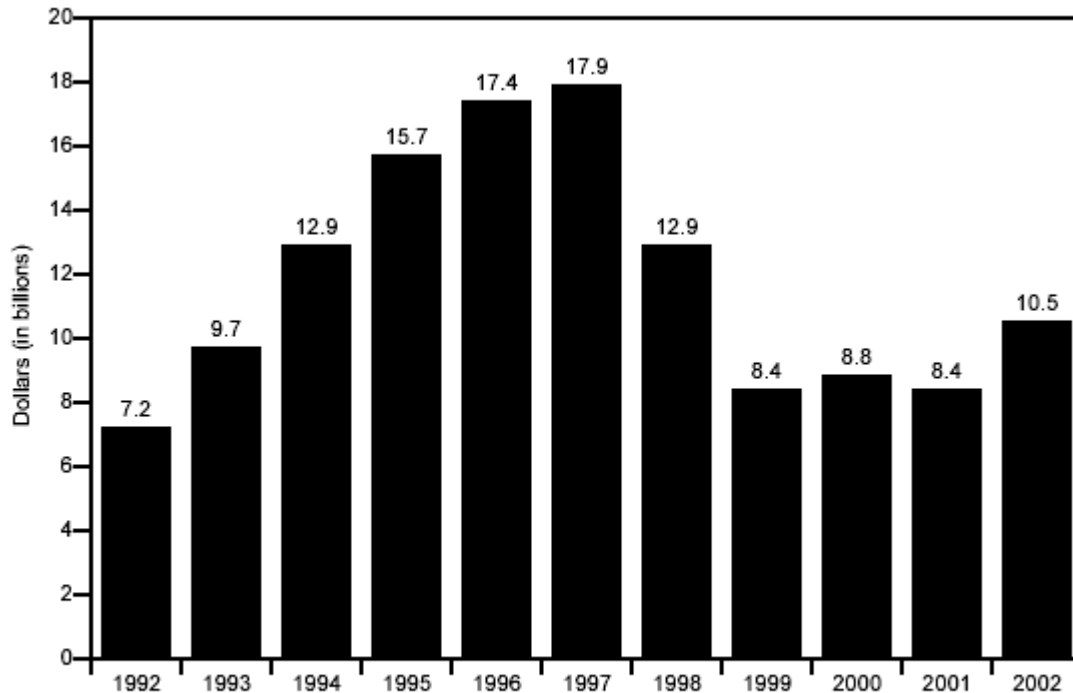
Sincerely,



Brian D. Ellsworth
President & CEO

Attachment I
Medicare Home Health Utilization
Source: Medicare Payment Advisory Commission, Data Book, June 2003

Chart 8-7. Spending for home health care, 1992–2002



Source: CMS, Office of the Actuary, 2003

- Medicare home health care spending grew at an average annual rate of 20 percent from 1992 to 1997. During that period, the payment system was cost based. Eligibility had been loosened just before this period and enforcing the program's standards became more difficult.
- Spending began to fall in 1997. The Congress passed the Balanced Budget Act of 1997, which introduced an interim payment system (IPS) based upon costs with limits. Eligibility was tightened. The Office of Inspector General implemented Operation Restore Trust to increase scrutiny of home health and other sectors with precipitous growth in spending.
- In 2000, the prospective payment system replaced the IPS. At the same time, eligibility for the benefit was broadened slightly. Enforcement of the Medicare program's integrity standards continues.
- More information on changes in home health spending can be found on the CMS website, available at <http://cms.hhs.gov/review/current.asp>.