

# Dobson | DaVanzo

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## Memorandum

**Date:** September 23, 2011

**To:** William A. Dombi  
National Association for Home Care & Hospice

**From:** Al Dobson, Audrey El-Gamil

**Subject:** **Updated Report: Impact of Proposed Legislation H.R. 2267/S. 277 on Medicare Expenditures**

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The National Association for Home Care & Hospice and the American Nurses Association commissioned Dobson DaVanzo and Associates, LLC (Dobson | DaVanzo) to determine the impact of The Home Health Care Planning Improvement Act (H.R. 2267; S. 277) on Medicare expenditures and projects savings from 2012-2021. This report updates that initial analysis that estimated the impact of a previous iteration of The Home Health Care Planning Act (S. 2814; H.R. 4993) (dated November 5, 2010). Under current Medicare regulation, to qualify for coverage of home health services, a patient's physician must certify that the patient is confined to his or her home and in need of skilled nursing care on an intermittent basis or physical therapy, speech language pathology, or occupational therapy. Only a physician can provide this coverage certification or recertification for additional episodes.

The Patient Protection and Accountable Care Act (ACA) required an additional activity (i.e., face-to-face encounter). The Final Rule for the Home Health Prospective Payment System (Final Rule),<sup>1</sup> beginning January 1, 2011, added a specific time frame to the face-to-face encounter requirement. A home health patient must have a face-to-face encounter with a physician or certain non-physician practitioners within 90 days prior to (or within 30 days of) the start of care. The face-to-face encounter can be provided by the physician

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<sup>1</sup> Home Health Prospective Payment System Final Rule, Released November 2, 2010.

or the non-physician practitioner, but the certification must be completed by the physician.

The proposed legislation (H.R. 2267; S. 277) would allow non-physician providers (defined as nurse practitioners, clinical nurse specialists, certified nurse-midwives,<sup>2</sup> and physician assistants) to complete the initial patient coverage certification or recertification for additional episodes. When a non-physician practitioner provides the certification (or recertification), Medicare would pay a reduced rate for the certification in comparison to the physician payment (85 percent of the physician payment rate).

In order to inform our model of the impact of proposed legislation on Medicare spending, we conducted a series of interviews with a convenience sample of 18 nurse practitioners, clinical nurse specialists, case workers, and discharge planners. We also interviewed several individuals with oversight experience in the certification process.

## Methods

Our model is based on the Congressional Budget Office (CBO) baseline estimate of home health spending from 2012 to 2021. This baseline, developed in March of 2011, incorporates the provisions of the ACA.<sup>3</sup> We adjusted this model, however, to include a 5.06 percent reduction in payment in 2012 due to case-mix, which is proposed in the Home Health Prospective Payment System Proposed Rule for Calendar Year 2012. The CBO baseline also includes a reduction in market basket of 1 percent for both 2012 and 2013, and a 1 percent productivity adjustment starting in 2015, as mandated in the ACA.

Two important model components are: 1) the annual number of Medicare home health episodes, and 2) the average number of home health episodes by user. A Dobson | DaVanzo analysis of the CBO March 2011 baseline from 2012 to 2021 served as the basis for our assumptions concerning the number of Medicare home health episodes. The Medicare Payment Advisory Commission (MedPAC) estimates from 2002 to 2009 served as the basis of our average number of home health episodes by user.<sup>4</sup> MedPAC's estimates of this average were inflated on the compound annual growth rate of each year of the study window, 2012 – 2021.

Based on the Physician Fee Schedule for 2011, we determined that the payment for a physician certification of a Medicare home health episode is \$53.00 (G0180), and a recertification is \$40.43 (G0179). Assuming that the first episode by each user receives a certification, and the remaining episodes receive recertifications, we calculated an average certification/recertification payment if performed by a physician.

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<sup>2</sup> Effective January 1, 2011 under ACA, clinical-midwives will be reimbursed at 100 percent of the physician rate for all provided services. We expect clinical-midwives to have little involvement in the certification of home health episodes.

<sup>3</sup> Congressional Budget Office's August 2010 Baseline: Medicare. August 25, 2010.

<sup>4</sup> Report to the Congress: Medicare Payment Policy. (March, 2011). Medicare Payment Advisory Commission. Table 8-3.

As the non-physician provider would be reimbursed at 85 percent of the physician rate, we calculated a 15 percent savings reduction in the payment for each episode certified by a non-physician provider (rather than a physician). We assume this average payment will increase at 1 percent per year due to likely Congressional “fixes” for the sustainable growth rate (SGR) and conversion factor.

Based on the survey of clinicians, we developed assumptions of the proportion of home health episodes that would be certified or recertified by a non-physician provider under the proposed legislation, as opposed to a physician. The program savings reflect beneficiary copayments of 20 percent and includes the Part B premium offset (25 percent).

### **Caveats**

Based on responses to the survey, there are several caveats that may affect our cost estimate.

- **Migration into Home Health from Facility-Based Settings:** Survey respondents were asked whether the face-to-face requirement set forth in the Final Rule is expected to change referral patterns from acute care hospitals to home health. We asked if administrative burden would result in patients being placed directly into facility-based care (by passing home health care) or discharged to the community without home health care. Additionally, participants were asked whether this proposed legislation would be able to mitigate potential out-migration from home health caused by the face-to-face certification requirement. Respondents indicated that the face-to-face requirement may cause a small proportion of patients to enter other care settings (typically more medically complex patients and those in rural areas). However, while the proposed legislation may mitigate patient migration to other settings by expanding the types of clinicians able to certify the home health admission, there is no indication of how many patients would leave, or return, to home health. In the event that the face-to-face requirement does cause an out-migration that could be mitigated by this proposed legislation, our savings estimates would be underestimated, as facility-based care is more expensive than home health.
- **Increase in Overall Home Health Utilization:** Survey respondents were asked whether the proposed legislation would increase the overall utilization of home health among patients that would not otherwise receive care. Respondents did not expect to see an increase in home health utilization from this population for several reasons. First, the stringency of Medicare home health eligibility does not permit a large proportion of Medicare beneficiaries to receive care in the home. The eligibility restriction for only homebound patients in need of skilled nursing care or therapy limits the number of beneficiaries eligible for this benefit. Since this proposed legislation would not alter the eligibility requirement for home health, rather it just increases the timeliness of receiving care and decreases the

administrative burden of the physicians and home health agencies, little change in utilization is expected. Second, of those who are eligible and in need of home health care, a very small proportion currently resides at home with no care. Therefore, any increase in home health utilization would likely be attributed to a substitution of home health care from other facility-based care settings as opposed to a “woodworking effect.”

- **Reduction in Facility-Based Length of Stay:** Respondents indicated that the proposed legislation could increase the timeliness of patient discharge from a hospital or facility-based setting into home health, possibly decreasing the respective lengths of stay. Again, to the extent that length of stay (especially skilled nursing facilities) would be reduced by non-physician providers completing home health certifications, our savings estimates would be underestimated. Prospective payment for long-term care or acute care hospitals is case-based and therefore is not impacted by length of stay (aside from payment outliers). On the other hand, skilled nursing facilities are paid on a per-diem basis so length of stay might be more relevant in this setting.
- **Non-Physician Provider Scope of Practice:** The scope of practice for clinical practitioners varies by state. Under current scope of practice limitations, non-physician providers in several states may not be authorized to complete home health certifications even if allowed under Medicare regulation. For the purpose of our analysis, we were unable to determine which states would be restrictive in scope of practice laws. (Our interviewees were decidedly mixed in their understanding of how, and if, state scope of practice regulations would affect our results.) Therefore, our cost estimate assumes that state laws do not preclude non-physician providers from performing the certification under the clinician’s scope of practice. This is consistent with initiatives to standardize state laws governing how nurses may practice.<sup>5</sup> A recent Institute of Medicine report addresses barriers that need to be overcome to ensure that nurses are well positioned to lead health reform and policy changes.<sup>6</sup>

## Results

Survey respondents indicated that, currently, non-physician providers occasionally complete the patient assessment to determine the eligibility of a patient for home health (the face-to-face encounter) on behalf of a physician prior to his/her certification of the home health episode. Under the proposed legislation, survey results indicate that there would be a rapid and large uptake rate of non-physician providers completing the face-to-

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<sup>5</sup> Naylor M, Kurtzman ET. (2010). The role of nurse practitioners in reinventing primary care. *Health Affairs* 29(5):893-899.

<sup>6</sup> Institute of Medicine. (2010). *Future of Nursing: Leading Change, Advancing Health*. Report Brief. Available at <http://www.iom.edu/~media/Files/Report%20Files/2010/The-Future-of-Nursing/Future%20of%20Nursing%202010%20Report%20Brief%20v2.pdf>.

face requirement and certification documents for the physician in the initial years of implementation. Our study window is 2012-2021, and our model projects that the rate of growth in the proportion of non-physician providers that complete home health certifications will slow in the out years.

Passing the proposed legislation is expected to decrease both administrative burden and cost for home health agencies. Additionally, the proposed legislation is expected to alleviate the administrative burden on physicians. Respondents opined that currently locating and obtaining documentation from physicians in a timely manner is often cumbersome or difficult. However, we expect that there will not be a full transition to non-physician certification due to physician preference, institution-specific guidelines, and patient referral protocols. Furthermore, we expect state workforce constraints to also impede a full transition.

Given the current role of non-physician providers in the home health certification process, and the likelihood that physicians would better utilize these providers if allowed, we assume that 20 percent of home health episodes will be certified by non-physician providers in 2012. Over the next ten years, we estimate that the proportion would increase to 70 percent, due to the increasing role played by non-physician providers in care transitions and reductions in the supply of primary care physicians.

In 2012, we estimate Medicare savings of \$6.9 million. We estimate a five-year savings to be \$91.9 million. From 2012 to 2021, Medicare could save approximately \$309.5 million by allowing non-physician providers to complete home health certifications. These cost savings above assume that all home health episodes will have an accompanying certification/recertification claim for Medicare payment.

However, according to our analysis of the 2010 Physician Supplier Procedure Summary File, only a portion of physicians actually bill Medicare for certifying (or recertifying) a home health patient episode. Out of the estimated 6.9 million home health episodes in 2011, physicians billed for only 3.2 million certifications or recertifications (G0180 or G0179), or for 47 percent of episodes.<sup>7</sup> Therefore, if the proportion of certifications (and recertifications) does not increase over time, we would expect that Medicare savings will only be 47 percent of our previous estimate, or \$129.2 million over 10 years.

Due to the face-to-face requirement under ACA, we anticipate that the proportion of episode certifications that are billed to Medicare by physicians would increase over time. However, with the passage of the proposed legislation, much of this increase in certification billing would be provided by non-physicians, hence leading to Medicare savings. Therefore, the final Medicare savings estimates will likely fall between these two extremes.

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<sup>7</sup> 2010 utilization of certifications (G0180) = 1.58 million; recertifications (G0179) = 1.61 million

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<b>Savings Estimate</b>	<b>Cumulative Estimated Medicare Savings</b>
1-Year Estimate (2012)	\$6.9 million
5-Year Estimate (2012-2016)	\$91.9 million
10-Year Estimate (2012-2021)	\$309.5 million
Alternate Model: 10-Year Estimate with no change in proportion of certification/recertifications to Medicare claims	\$129.2 million

Note: Other than in the alternate model, these cost savings assume that Medicare is billed for every home health episode certification or recertification (G0180 or G0179).

Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2012-2021
<b>Inputs</b>											
Actual CBO Home Health Baseline (in millions) (1)	\$19,558	\$21,267	\$23,231	\$25,014	\$26,801	\$28,486	\$30,285	\$32,184	\$34,183	\$36,282	\$277,292
Number of Total Home Health Episodes (2)	7,043,219	7,536,185	8,229,692	8,932,230	9,634,873	10,307,587	10,751,625	11,215,529	11,701,518	12,200,425	97,552,884
Average Home Health Episodes per User (3)	2.2	2.3	2.3	2.4	2.5	2.6	2.7	2.8	2.8	2.9	
Weighted Average Payment for Certification/Recertification (4)	\$54.51	\$56.16	\$57.86	\$59.61	\$61.43	\$63.30	\$65.23	\$67.22	\$69.28	\$71.41	
<b>Step 1: Payment for Certification Services (in millions)</b>											
Proportion certification by non-physician providers	20.0%	35.0%	45.0%	50.0%	53.3%	56.7%	60.0%	63.3%	66.7%	70.0%	
Cost if all done by Physician	\$384	\$423	\$476	\$532	\$592	\$652	\$701	\$754	\$811	\$871	
Cost of non-physician for given percent (in millions)	\$65.3	\$125.9	\$182.1	\$226.3	\$268.3	\$314.3	\$357.7	\$405.9	\$459.4	\$518.4	
Cost of physician for residual percent	\$307.1	\$275.1	\$261.9	\$266.2	\$276.2	\$282.7	\$280.5	\$276.4	\$270.2	\$261.4	
<b>Savings from Non-Physician Provider Certification</b>	<b>-\$11.5</b>	<b>-\$22.2</b>	<b>-\$32.1</b>	<b>-\$39.9</b>	<b>-\$47.3</b>	<b>-\$55.5</b>	<b>-\$63.1</b>	<b>-\$71.6</b>	<b>-\$81.1</b>	<b>-\$91.5</b>	<b>-\$515.9</b>
<b>Step 2: Payment for Certification Services Net Beneficiaries Co-payments (in millions)</b>											
Cost if all done by Physician net 20% co-payment	\$307.14	\$338.57	\$380.92	\$425.99	\$473.47	\$521.95	\$561.05	\$603.16	\$648.57	\$696.96	
Cost of non-physician for given percent net 20% co-payment	\$52.21	\$100.73	\$145.70	\$181.04	\$214.64	\$251.41	\$286.14	\$324.70	\$367.52	\$414.69	
Cost of physician for residual percent net 20% co-payment	\$245.72	\$220.07	\$209.51	\$212.99	\$220.95	\$226.18	\$224.42	\$221.16	\$216.19	\$209.09	
<b>Medicare Program Savings Net Beneficiary Co-payments</b>	<b>-\$9.2</b>	<b>-\$17.8</b>	<b>-\$25.7</b>	<b>-\$31.9</b>	<b>-\$37.9</b>	<b>-\$44.4</b>	<b>-\$50.5</b>	<b>-\$57.3</b>	<b>-\$64.9</b>	<b>-\$73.2</b>	<b>-\$412.7</b>
<b>Total Impact</b>											
Actual CBO Home Health Baseline (in millions) (1)	\$19,558	\$21,267	\$23,231	\$25,014	\$26,801	\$28,486	\$30,285	\$32,184	\$34,183	\$36,282	
Medicare Savings Net of 20% Beneficiary Co-Payments	-\$9.2	-\$17.8	-\$25.7	-\$31.9	-\$37.9	-\$44.4	-\$50.5	-\$57.3	-\$64.9	-\$73.2	
Medicare spending after 25% Part B premium	-\$6.9	-\$13.3	-\$19.3	-\$24.0	-\$28.4	-\$33.3	-\$37.9	-\$43.0	-\$48.6	-\$54.9	
<b>Total Savings (in millions)</b>	<b>-\$6.9</b>	<b>-\$13.3</b>	<b>-\$19.3</b>	<b>-\$24.0</b>	<b>-\$28.4</b>	<b>-\$33.3</b>	<b>-\$37.9</b>	<b>-\$43.0</b>	<b>-\$48.6</b>	<b>-\$54.9</b>	<b>-\$309.5</b>
<b>Modeled Baseline (in millions)</b>	<b>\$19,565</b>	<b>\$21,280</b>	<b>\$23,251</b>	<b>\$25,038</b>	<b>\$26,829</b>	<b>\$28,519</b>	<b>\$30,323</b>	<b>\$32,227</b>	<b>\$34,232</b>	<b>\$36,337</b>	<b>\$277,601</b>

(1) CBO March 2011 Baseline with additional 5.06% decrease in payments 2012 for case-mix adjustment

(2) Dobson | DaVanzo analysis of CBO March 2011 Baseline

(3) MedPAC March 2010 Table 8-3; number of home health episodes per user, inflated by CAGR 2002-2009

(4) Weighted average payment of certification and recertification (G0180 & G0179) based on 2010 Physician Fee Schedule and number of home health episodes per user, inflated by 1% per year due to likely Congressional "fixes" to SGR

<b>Summary of Findings</b>	
1-year Savings Estimate (in millions)	-\$6.9
5-year Savings Estimate (in millions)	-\$91.9
10-year Savings Estimate (in millions)	-\$309.5