Dobson | DaVanzo

Dobson DaVanzo & Associates, LLC 440 Maple Avenue East, Suite 203, Vienna, VA 22180 703.260.1760
www.dobsondavanzo.com

# Memorandum

**Date:** March 25, 2014

**To:** Rose Gonzalez, American Nurses Association
Mary Anne Sapio, American Association of Nurse Practitioners

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

**Subject:** **Updated Report: Impact of Proposed Legislation H.R. 2504/ S. 1332 on Medicare Expenditures**

---

American Nurses Association and American Association of Nurse Practitioners commissioned Dobson DaVanzo and Associates, LLC (Dobson | DaVanzo) to update its assessed impact of The Home Health Care Planning Improvement Act (H.R. 2504; S. 1332 ) on Medicare expenditures. The projected savings for this legislation have been updated over time, under contract with the National Association of Homecare and Hospice (NAHC).[1] This report updates the two previous analyses and projects savings from 2015 through 2024.

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 Affordable Care Act (ACA) required an additional activity (i.e., face-to-face encounter). Implemented in the 2011 Final Rule for the Home Health

---

[1] The initial impact on Medicare expenditures was assessed for a previous iteration of The Home Health Care Planning Act (S. 2814; H.R. 4993) (dated November 5, 2010). A subsequent revision (H.R. 2267; S. 277) was completed with savings projected from 2012-2021.

Prospective Payment System (Final Rule),[2] beginning January 1, 2011, 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 or the non-physician practitioner, but the certification must be completed by the physician.

The proposed legislation (H.R. 2504; S. 1332) would allow non-physician providers (defined as nurse practitioners, clinical nurse specialists, certified nurse-midwives,[3] 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.[4]

## Methods

Our model is based on the Congressional Budget Office (CBO) baseline estimate of home health spending projected from 2013 to 2022.[5] This baseline, developed in May of 2013, incorporates the provisions of the ACA including productivity adjustments and sequestration. We adjusted this model, however, to include the impact of the 2014 Home Health Prospective Payment System Final Rule, which included rebasing home health payment rates between 2014 and 2017.

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 May 2013 baseline from 2013 to 2022 served as the basis for our assumptions concerning the number of Medicare home health episodes. The Medicare Payment Advisory Commission (MedPAC) estimates for 2002 to 2011 served as the basis of our average number of home health episodes by user.[6] MedPAC's

[2] Home Health Prospective Payment System Final Rule, Released November 2, 2010.

[3] 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.

[4] The interviews were completed during the initial assessment of this policy on Medicare expenditures. The interviews were not conducted again for subsequent revisions to the savings estimates, which were completed since the face-to-face requirement was implemented.

[5] Congressional Budget Office's May 2013 Medicare Baseline. May 14, 2013.

[6] Report to the Congress: Medicare Payment Policy. (March, 2013). Medicare Payment Advisory Commission. Table 9-1; Table 9-3.

estimates of this average were inflated on the compound annual growth rate up to, and through each year of the study window, 2015 – 2024.[7]

Based on the Medicare Physician Fee Schedule for 2014, we determined that the payment for a physician certification of a Medicare home health episode is $53.38 (G0180), and a recertification is $41.20 (G0179).[8] 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.

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 the conversion factor used to determine this average payment will be frozen at 2014 rates for the remainder of the budget window, consistent with the most recent bipartisan sustainable growth rate (SGR) replacement framework.[9]

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. As the surveys were conducted prior to implementation of the policy, respondents indicated that the face-to-face requirement may cause a

[7] This growth rate seems compatible with the continued emphasis on home and community-based care aimed to reduce readmissions and other facility-based care.

[8] The Pathway for SGR Reform Act of 2013 implemented a conversion factor of $35.8228 through March 31, 2014. This conversion factor was used to determine the 2014 payment rate.

[9] While this bipartisan policy was not implemented in 2013 (and was replaced by a "patch" set to expire on March 31st), it was the most recent policy with bipartisan support to support a complete replacement of SGR (as opposed to a patch). While the discussion draft froze the conversion factor through 2023, we assumed the freeze would continue through the entire budget window.

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 increased facility-based care would be more expensive than the home health care replaced.

- **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, little change in utilization is expected. This legislation would, however, likely increase the timeliness with which patients receive care and decrease the administrative burden of the physicians and home health agencies. This increased timeliness could result in faster patient recovery and reduce the likelihood for, and impact of, patient deconditioning. 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 inpatient rehabilitation facilities and 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**: 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.[10] An 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.[11]

## 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-face requirement and certification documents for the physician in the initial years of implementation. Our study window is 2015-2024, 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 administrate 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 2015. 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 2015, we estimate Medicare savings of $7.1 million. We estimate a five-year savings to be $82.5 million. From 2015 to 2024, Medicare could save approximately $252.6 million by allowing non-physician providers to complete home health certifications. Since Medicare Advantage (MA) often aligns its payment rates to the fee-for-service Medicare rates, this policy could produce additional savings within the MA market. While we do not include these additional savings in our assessment of this policy, the

[10] Naylor M, Kurtzman ET. (2010). The role of nurse practitioners in reinventing primary care. Health Affairs 29(5):893-899.

[11] 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.

total savings, net of the offsets to account for beneficiary co-payments and a reduction in Part B premiums, could be increased by 30 percent.

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 2012 Physician Supplier Procedure Summary File, only a portion of physicians actually bill Medicare for certifying (or recertifying) a home health patient episode, despite the policy requirement. Out of the estimated 7.0 million home health episodes in 2012, physicians billed for only 2.9 million certifications or recertifications (G0180 or G0179), or for 42 percent of episodes.[12] Therefore, if the proportion of certifications (and recertifications) does not increase over time, we would expect that Medicare savings will only be 42 percent of our previous estimate, or $107.0 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.

| **Savings Estimate** | **Cumulative Estimated Medicare Savings** |
|---|---|
| 1-Year Estimate (2015) | $7.1 million |
| 5-Year Estimate (2015-2019) | $82.5 million |
| 10-Year Estimate (2015-2024) | $252.6 million |
| Alternate Model: 10-Year Estimate with no change in proportion of certification/recertifications to Medicare claims | $107.0 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).

[12] 2012 utilization of certifications (G0180) = 1.51 million; recertifications (G0179) = 1.45 million