INSIGHT on the Issues

Removing Barriers to Advanced Practice Registered Nurse Care: Home Health and Hospice Services

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The landmark 2011 Institute of Medicine report, *The Future of Nursing, Leading Change, Advancing Health,* recommends that advanced practice registered nurses (APRNs) be allowed to certify patients for Medicare payment of home health and hospice services.[1] However, Medicare laws and regulations prohibit APRNs from conducting certification for these services. This report shows how removing this barrier would benefit consumers, physicians, and the health care system.

Advanced practice registered nurses (APRNs) provide high-quality primary care on a daily basis in communities across the nation,[2] particularly in rural and underserved areas.[3] APRNs also play a vital role in providing care coordination for people with multiple diseases and chronic conditions. Their advanced education and training equips APRNs with the knowledge and experience to refer patients for home health and hospice services. Despite this, Medicare rules and regulations do not allow ARPNs to sign certification documents to allow consumers to receive these needed services.

What are Home Health and Hospice Services?

Home health and hospice services are Medicare benefits provided to beneficiaries in their homes, including wound care, physical and occupational therapy, patient and caregiver education, and monitoring serious illness and unstable health status. These Medicare services were designed to be short-term, post-hospitalization health care services.[4] A Medicare beneficiary who requires the skilled services of a registered nurse or therapist may also receive personal care services, such as help with bathing or meals, from a home health aide. About 10 percent of Medicare beneficiaries use home health services each year,[5] allowing them to receive nursing care and other health services at home as an alternative to extended hospital stays or nursing home care.

Physicians are the gatekeepers of the Medicare home health benefit, but nursing is the fundamental home health service.[6] In order for a Medicare beneficiary to receive home health services, a physician must certify that the patient is homebound and requires skilled services, such as nursing care or physical therapy.

Who are Advanced Practice Registered Nurses?

Advanced Practice Registered Nurses (APRNs):

- Are registered nurses (RNs) with master's, post-master's, or doctoral degrees.
- Pass national certification exams.
- Teach and counsel patients to understand their health problems and what they can do to get better.
- Coordinate care and advocate for patients in the complex health system.
- Refer patients to physicians and other health care providers.

AARP

Types of Advanced Practice Registered Nurses

Who are they?	How many in U.S.?	What do they do?
Nurse Practitioners (NP)	158,348	Take health histories and provide complete physical exams; diagnose and treat acute and chronic illnesses; provide immunizations; prescribe and manage medications and other therapies; order and interpret lab tests and x-rays; provide health teaching and supportive counseling.
Clinical Nurse Specialists (CNS)	59,242*	Provide advanced nursing care in hospitals and other clinical sites; provide acute and chronic care management; develop quality improvement programs; serve as mentors, educators, researchers, and consultants.
Certified Registered Nurse Anesthetists (CRNA)	34,821	Administer anesthesia and related care before and after surgical, therapeutic, diagnostic, and obstetrical procedures, as well as pain management. Settings include operating rooms, outpatient surgical centers, and dental offices. CRNAs deliver more than 65% of all anesthetics to patients in the U.S.
Certified Nurse-Midwives (CNM)	18,492	Provide primary care to women, including gynecological exams, family planning advice, prenatal care, management of low risk labor and delivery, and neonatal care. Practice settings include hospitals, birthing centers, community clinics and patient homes.

Sources: AARP Public Policy Institute, Center to Champion Nursing in America, *Preparation and Roles of Nursing Care Providers in America*. Washington, DC, 2009. U.S. Department of Health and Human Services, Health Resources and Services Administration, *The Registered Nurse Population: Initial Findings from the 2008 National Sample Survey of Registered Nurses*. Washington, DC, 2010. *(*APRNs are identified by their responses to the National Sample Survey and may not reflect the true population of clinical nurse specialists.)*

Hospice services are provided by a team of health care professionals and support staff to terminally ill patients and their families in their home or in an inpatient facility.[7] The Medicare hospice benefit includes nursing care, pain medication, and personal care services for terminally ill patients, as well as counseling and support for their family caregivers.[8] Unlike Medicare home health services, there is no requirement that the hospice beneficiary be homebound. Both Medicare home health and hospice services are provided to beneficiaries without the need to pay any deductibles or copayments.

Medicare requires that a physician certify that a hospice patient's life expectancy is six months or less. This requirement assumes that there is a reasonable probability—not certainty—of the hospice beneficiary's prognosis.[9]

Although several studies have found that the vast majority of people would prefer to die at home,[10] according to the latest Medicare information available, only about 42 percent of Medicare beneficiaries who died in 2009 used hospice services, up from about 23 percent in 2000.[11]

Medicare Rules for Home Health and Hospice Services May Pose Barriers to Care

Medicare laws and regulations regarding the role of APRNs are inconsistent. For example, Medicare specifies that only a physician (not an APRN or physician assistant) may order home health services.[12,13,14] Medicare regulations also specifically exclude nurse practitioners (NPs) from being allowed to certify patients for hospice.[15]

However, since 2003, NPs have been authorized to act as "attending physicians" for hospice patients.[16] Medicare hospice regulations define an attending physician

as a "doctor of medicine or osteopathy or a nurse practitioner [who] is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care."[17]

Furthermore, although Medicare does not allow NPs or other APRNs to certify patients for hospice or home health services, since 1995, APRNs have been authorized to certify patients for post-hospitalization extended care services in skilled nursing facilities. Medicare accepts APRN signatures on certification or recertification forms to enable beneficiaries to receive postacute care and rehabilitation for complex medical conditions such as joint replacement, stroke, and heart failure.[18]

APRNs Play a Significant Role Preventing Medicare Fraud

The Medicare Payment Advisory Commission (MedPAC) has expressed concern regarding fraudulent overuse of Medicare home health and hospice services.[19] The Office of the Inspector General found that home health agencies received $432 million in overpayments for services that were not medically necessary. The Medicare beneficiaries who received these services were not homebound, not in need of skilled nursing care, or not under the care of a physician. The overpayment of $432 million represents about 2.5 percent of the total $17 billion in Medicare home health payments in 2008.[20]

To reduce Medicare payment fraud, as part of the Patient Protection and Affordable Care Act, Medicare now requires a face-to-face encounter to certify eligibility for home health and hospice services. The face-to-face encounter may take place in a physician's office, a hospital or other health care setting, or in the patient's home. In rural areas, the encounter may be conducted via telehealth technology.

The requirement for a face-to-face encounter was designed to combat fraud by ensuring that physicians and other health care providers have met the patients in person and determined that they are indeed eligible for Medicare home health or hospice benefits.[21]

Although only physicians may certify patients for home health and hospice services, the face-to-face encounter may be performed by NPs, clinical nurse specialists, and physician assistants (PAs), in addition to physicians. These nonphysician providers are required to document the clinical findings of the encounter and communicate those findings to the certifying physician. The certifying physician then writes a narrative based on those clinical findings that supports the patient's homebound status and need for skilled services. Medicare provides an example of a physician narrative on its website:

> The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT [physical therapy] is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition or adverse events from the new COPD [chronic obstructive pulmonary disease] medical regimen.[22]

For hospice services, only physicians or NPs are authorized to perform the face-to-face encounter. Clinical nurse specialists and PAs are excluded. If a hospice NP performs the face-to-face encounter, the NP must attest in writing the visit date and "state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient [has]…a life expectancy of 6 months or less, should the illness run its normal course."[23]

Having APRNs perform the face-to-face encounter and then requiring written

documentation of the encounter by both the APRN *and* the certifying physician often delays access to needed care and increases costs.

The Institute of Medicine Recommends that APRNs Be Authorized to Certify Home Health and Hospice Services

The Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health* recommends that APRNs be authorized to certify eligible patients for home health and hospice services.[24] Ordering home health services is within the scope of practice of an NP, clinical nurse specialist, and certified nurse midwife.[25] These APRNs have advanced education and training and are capable of determining if a Medicare recipient is homebound and in need of skilled nursing or therapy services in the home, as well as in a nursing home.

NPs who work in hospice settings are educated and trained in the care of terminally ill patients. Estimating prognosis and predicting survival for a patient with a terminal diagnosis is based on the natural history of the disease, the patient's functional status, signs and symptoms, and laboratory and other diagnostic tests.[26] NPs who function as hospice "attending physicians" are well informed about their patients' medical history and current status. These NPs are capable of determining if a patient has a terminal illness with a life expectancy of six months or less.

The Benefits of Allowing APRNs to Authorize Home Health and Hospice Services

Consumers will benefit from more direct access to home health and hospice services. Since 2010, AARP has supported proposed legislation to allow APRNs to certify home health services.[27] AARP is committed to ensuring that consumers have access to health care providers who are qualified, educated, and certified to provide high-quality primary care, chronic care management, and other services that help them live a high-quality life, with dignity, in locations of their choice.[28]

For the vast majority of older Americans, that location is home.[29] For homebound patients, the current requirement that a physician sign-off on APRN recommendations for home care services may delay care and may result in hospitalizations that could have been avoided.

Allowing APRNs to authorize home health and hospice services could increase access and reduce costs. At present, if an NP sees a patient in a medical office or on a house call—and more NPs are going into independent house call practices (see "Manhattan House Calls" box)—and determines that the patient needs home health or hospice services, the NP is required to ask a physician to sign the home health or hospice forms. Some physicians will charge the NP a fee for signing Medicare certification forms. Other physicians will not certify home health or hospice services unless they have seen the patient. This means an extra visit to a physician's office for a homebound patient—often by ambulance.

Allowing APRNs to authorize home health and hospice services could reduce delays in care for vulnerable, homebound patients (see "Mobile Medicine" box). APRNs are willing to provide services in areas where access to physicians is limited, including underserved urban and remote rural areas. More than two-thirds of NPs practice in primary care settings, and 18 percent practice in remote rural or frontier settings.[30]

Physicians will benefit when APRNs can certify home health and hospice services.

Allowing APRNs to sign certification forms would reduce the paperwork piles in medical offices throughout the country. In a public meeting held on January 15, 2010, MedPAC discussed the face-to-face encounter as a way to reduce home health service overuse and to prevent Medicare fraud. MedPAC commissioner William Scanlon recommended that NPs not only perform the face-to-face encounter but also be able to certify patients for home health services. Dr. Scanlon advised that NPs were capable of making certification decisions and that this would increase efficiency and "take a burden off physicians."[31]

Allowing the APRN who performs the face-to-face encounter that is used to determine eligibility for home health and hospice services to also write and sign the required narrative would eliminate a tedious, unnecessary task for physicians. Since about half of all office-based physicians work with an APRN or PA,[32] removing the requirement for physician sign-off would be a welcome reduction in physician workload. Medicare recently acknowledged the administrative burden associated with physician documentation of APRN or PA performed face-to-face encounters by proposing a special payment code of $15 for this administrative task.[33]

The health care system will benefit when APRNs can certify home health and hospice services.

Home health and hospice providers could gain efficiencies if APRNs could certify home health and hospice services. Locating and obtaining documentation from physicians for home care and hospice certification is cumbersome and expensive for home health agencies.[34]

NP and physician practices would also benefit. Allowing APRNs to certify home health and hospice services would eliminate the need for NP practices to put their collaborating physician's name on home health or hospice orders, lab requests, or patient summaries. Valuable medical staff office time would no longer be used notifying physicians about home health or hospice orders or test results of homebound patients they have never seen nor ever will see (see "Advanced Geriatric Education & Consulting LLC" box).

Allowing APRNs to certify home health services could result in $129.2 million to $309.5 million cost savings for Medicare in the next 10 years.[35] Cost savings in this report are based on the 15 percent reduction in Medicare payment when a service is billed by a nonphysician provider. Cost estimates for allowing APRNs to certify hospice services have not been determined, but because the numbers of NPs who practice as hospice attending physicians are very small, accounting for just 4 percent of Part B Medicare Hospice services in 2006,[36] minor cost reductions could result.

Indirect costs of this barrier to APRN practice and care include visits to physicians, often by ambulance, by homebound beneficiaries for the sole purpose of getting certifications signed, as well as unnecessary emergency department visits or hospitalizations due to delays in home health or hospice services because of unsigned certification forms. These indirect costs have not been calculated, but allowing APRNs to certify home health and hospice services could surely reduce overall costs to the health care system.

Conclusion

Removing barriers to APRN care in home health and hospice services will benefit consumers, nurses, physicians, and the health care system. Removing these barriers, which will require legislative action, would increase access to care for

vulnerable patients and their family caregivers. Continuity of care would improve if the NPs who provide house calls or other primary care services could be the providers of record for their patients' Medicare home health and hospice services. Allowing APRNs to certify home health and hospice services can potentially decrease costs, expedite treatment by eliminating the need for physician sign-off, and allow patient-centered health care teams to practice more efficiently.

Manhattan House Calls, LLC

"For many seniors, accessing medical care can be both financially and physically demanding. By performing medical house calls, we strive to alleviate this burden."

— DENIS F. TARRANT, NP

Nurse practitioner Denis Tarrant submits more than 300 certifications for home health services each year, and not one of these patients has seen a physician. Denis's homebound patients are able to receive home health services under Medicare because his physician collaborator is willing to sign the certification documents. For this Medicare requirement, Denis pays the physician collaborator $15,000 annually.

Denis is an associate member of the American Academy of Home Care Physicians and says that often physician members post on the academy's listserv their support for the passage of federal legislation to allow APRNs to certify home health services.

Effective January 1, 2011, as part of the Affordable Care Act, Medicare requires a face-to-face encounter by the certifying physician or a nonphysician provider (nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant). For Denis, this requirement means one more document that he fills out and submits to his collaborating physician for signature. Denis says that by allowing nurse practitioners to see the patient and having the physician sign off on the nurse practitioner's statement, Medicare is acknowledging that physicians do not have the time or capacity to see every patient who needs home health care. It would be in the patient's best interest that the provider who makes the house call be the provider who certifies the need for home health services and communicates those needs to the Medicare-certified home health agency.

Mobile Medicine

Biking nurse makes house calls in Bellingham, Washington.
http://www.bellinghamherald.com/2010/10/15/1671247/bellingham-nurse-practitioner.html.

Jody Hoppis, an adult nurse practitioner, owns a house calls practice in Bellingham, Washington. She travels by bicycle to her clients' homes and workplaces, transporting medical supplies behind her. As an independent nurse practitioner in Washington State, Jody can practice to the full extent of her education and training, including prescribing medications and physical therapy, ordering and interpreting diagnostic tests, and referring patients to specialists. The largest barrier to this APRN practice is the Medicare requirement for physician certification of home health services. Jody had to find a physician willing to countersign home health orders and set up a contract. Since the physician's office is located two hours away, Jody spends time and resources faxing authorizations back and forth between her practice, the physician, and home health agencies. This barrier has already had a detrimental effect on one of Jody's homebound patients. This patient had not been out of bed for four years and welcomed Jody's visit. On the initial visit, Jody diagnosed a wound and recommended visiting nurse services. It took more than a week for Jody to obtain authorization for wound care for this patient and for the home health agency to accept the orders. The delay in care resulted in a significantly larger wound and delayed the patient's treatment and recovery.

Advanced Geriatric Education & Consulting, LLC

Phyllis Atkinson has been a registered nurse for 32 years and a geriatric nurse practitioner (GNP) for 18 of those years. For the past three years, she and her business partner Kathy Ferriell have made house calls to frail older adults through Advanced Geriatric Education & Consulting, LLC (AGE). Their clients, like most older adults, want to stay in their own homes as long as possible.

The Medicare rule that does not permit GNPs to order home health and hospice services is a daily problem, causing delays in care and unnecessary emergency department visits and hospitalizations. Home health agencies have interpreted the outdated Medicare rule to mean that they cannot accept any telephone orders from NPs. Fortunately, the AGE house calls practice collaborates with the geriatric department of Wright State Physicians, which will sign home care and hospice orders for Phyllis and Kathy's patients. Unfortunately, this arrangement creates confusion and delays care. Since the home health agency will not accept orders from NPs, lab tests and other diagnostic tests must be written with the collaborating physician's name on the lab slip. Results are then faxed to the large academic physician practice, not the house calls practice. Administrative staff at the Wright State geriatric practice waste time notifying physicians about lab results on patients they have not seen and are not they following, NPs spend time trying to track results, and both NPs and physicians spend unnecessary time away from their patients.

The Wright State Physicians who practice in the department of geriatrics are happy to collaborate with the AGE house calls practice but would be much happier if they were not required to sign Medicare forms or receive lab results on patients not under their care. Home health and hospice nurses would prefer to communicate directly with the patients' primary care provider—in this case, the NP who sees the patients in their homes. Patients would prefer to stay in their homes and be able to receive complete, comprehensive care from primary care providers who know them best.

Endnotes

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