



Home check: Nurse practitioner Marie Grosh visits Leroy Zacharias once a month at his home in a Cleveland suburb, where he lives with his wife, Bridget, and his dog, Snickers. Grosh checks Zacharias's vital signs, examines him, refills any prescriptions, and asks about changes in his health. He has Parkinson disease, and Grosh says he would be living in a nursing home if he couldn't get medical care at home.

By Susan Jaffe

REPORT FROM THE FIELD

Home Health Care Providers Struggle With State Laws And Medicare Rules As Demand Rises

DOI: 10.1377/hlthaff.2019.00529
HEALTH AFFAIRS 38,
NO. 6 (2019): 981-986
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When Christine Williams began working as a nurse practitioner some forty years ago in Detroit, Michigan, older adults who couldn't manage on their own and had no family nearby and no doctor willing to make house calls had few options besides winding up in a nursing home.

Not anymore.

"The move towards keeping seniors in their homes is a fast-galloping horse here," says Williams, who settled in Cleveland, Ohio, more than a decade ago. "We don't have space for them

in long-term care [facilities], they don't want to be in long-term care, and states don't want to pay for long-term care. And everybody wants to live at home."

But despite the growing desire for in-home medical care for older adults from nearly all quarters, seniors' advocates and home health professionals claim that rules set by the Centers for Medicare and Medicaid Services (CMS) along with state regulations have created an obstacle course for the very providers best positioned—and sometimes the only option—to offer that care.

Susan Jaffe (Jaffe.KHN@gmail.com) is a contributing writer for Kaiser Health News and the Washington, D.C., correspondent for the *Lancet*. She is based in Washington, D.C.

Tectonic shifts in America's demographics have complicated these challenges. No one is getting any younger, including the baby-boom generation and the primary care physicians they depend on. Newly minted physicians are increasingly forgoing primary care in favor of more lucrative specialties accompanied by greater apparent prestige. A recent study found that only 2 percent of medical graduates chose a career in primary medicine.¹ By 2032, the Association of American Medical Colleges says, the US will have a shortfall of as many as 55,200 primary care physicians,^{2(pviii)} driven largely by a nearly 50 percent increase in the number of people older than age sixty-five during the same time period.^{2(p ix)}

As the demand for home and community-based care skyrockets, one response to the declining number of primary care physicians has been to rely on nurse practitioners, advanced practice registered nurses (APRNs) who may work in a clinical or home setting. Many nurse practitioners visit patients' homes, where they can diagnose and treat acute and chronic illnesses, administer immunizations and intravenous drugs, prescribe and manage medications, and order and interpret lab tests and x-rays, among other things.

When Wendy Wright, an APRN, opened her second nurse practitioner clinic eight years ago in Concord, New Hampshire, no primary care providers were accepting new patients, she says. By the end of her first year in business, the clinic was serving a thousand patients. The state's over-sixty-five population increased 39.9 percent in the decade ending in 2016.³

"We're very rural, and without the 1,800 nurse practitioners here in this state, patients would not have access to care," she says. "That's a reality." Although they can provide many of the same primary care services as physicians, nurse practitioners have encountered some notable—some would say illogical—state and federal limits on what kind of care they can deliver and where they can deliver it. Scope-of-practice restrictions on nurse practitioners vary across the country, with twenty-two states and the District of Columbia allowing nurse practitioners to practice to the full extent of their education and training without physician supervision.⁴ Other states require different degrees of physician oversight and approval.

But even in the least restrictive "full-practice" states, a separate rule under Medicare—the federal program that pays the medical bills for nearly sixty million older or disabled people—creates another obstacle to home health care that may prove to be even more intractable than state limitations.

Rules Of The Road

About 3.4 million^{5(p231)} Medicare beneficiaries received home care in 2017—a 38 percent increase since 2000—at a cost of \$17.7 billion. Medicare covers home health care with no copayments or deductibles as long as patients cannot leave home without great difficulty and need intermittent nursing, physical therapy, or other skilled care that only a trained professional can provide or supervise. The patient need not show improvement, although it took a lawsuit against CMS to clarify that point.^{6,7}

Those who qualify can also receive home health care aide services for help with dressing, bathing, and other daily activities. Medicare coverage for home health aide and nursing services is limited to thirty-five hours a week.⁸

But misconceptions among some providers and patients about Medicare's home health coverage creates additional obstacles to getting this care, says Judith Stein, executive director of the Center for Medicare Advocacy, which brought the lawsuit against CMS.

"There is next to no attention being paid to the extraordinary shrinking of the legally authorized Medicare home health benefit," she says.

Because the system has been vulnerable to fraudulent billing by some unscrupulous home health care agencies, the federal government stepped up efforts to scrutinize claims, prosecuted some providers for Medicare fraud, and instituted statewide moratoriums on new home health agencies in Florida, Illinois, Michigan, and Texas.^{5(p236)} Congress also took steps to curb fraud and abuse in the home health industry, by way of a provision of the Affordable Care Act (ACA). It requires any one of a variety of clinicians—physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant—to evaluate whether home health care is medically necessary only after meeting the patient "face-to-face."⁹

Yet the face-to-face encounter, which can be conducted by a nonphysician provider, is just one step in the home health care certification process. According to rules that predate the ACA, Medicare allows only physicians—no other providers—to "certify" that a patient needs home health care. The physician must also confirm that the patient is confined to his or her home, cannot leave without difficulty, and therefore needs medical treatment provided at home.

Another step in the process requires the physician to confirm that the patient has a plan of care and to review it periodically. In addition, the home health care services must be provided while the patient is under the care of a physician or following that care.

But physicians do not have to see the patient.

Some may rely on the nurse practitioner's judgment, while others may insist that the patient travel to the office for an appointment. In the latter situation, Medicare pays for the doctor to repeat what the nurse practitioner has essentially already done, says William Dombi, president of the National Association for Home Care and Hospice.

Such bifurcated rules have created a sometimes awkward disconnect in which nonphysicians can conduct the crucial face-to-face assessment on their own and provide the additional documentation showing that the patient meets the eligibility criteria but are still dependent on physicians to sign the paperwork. "You have a benefit that was designed back in the sixties that has not been modified to take into account even the concept of delegation," Dombi says.

"We can send prescriptions to the pharmacy, including [for] narcotics," says Marie Grosh, a former nursing home administrator who is now a geriatric advanced practice nurse practitioner and the owner of a medical house calls practice in a Cleveland suburb. "We can order lab work, x-rays, ultrasounds, EKGs [electrocardiograms]; interpret them; and treat patients based on that. But we're just not allowed to order home care—which is absurd."

Grosh visits her patients at least once a month and more often when necessary. If she thinks that a patient needs additional care, she can order services from a home health care agency, but Medicare won't pay for the services unless a physician completes the certification form.

In addition, Ohio requires that Grosh have a contract with a physician to practice in the state. In the Cleveland area, most physicians are affiliated with one of the three highly competitive hospital systems. Grosh says that physicians cannot contract with nurse practitioners like her outside their medical organization. The collaborating physician with whom she has a contract is retiring soon and probably will not renew their contract. If she can't replace him, she'll have to close her clinic, and her patients will have to fend for themselves.

"These are patients that have costly and time-consuming conditions. They're diabetics, they have heart failure or dementia," she says. "It's really difficult for them to get out of the home."

Some nurses who work in hospitals also think it's time for a change, to lift "restrictions on advanced practice registered nurses and their ability to provide certain home health services," says Robyn Begley, the chief nursing officer at the American Hospital Association (AHA) and CEO of the American Organization of Nurse Executives, which is part of the AHA. APRNs can provide more cost-effective care for both patients

and hospitals, Begley says, and outcomes are the same or better for patients treated by APRNs compared to those treated by primary care physicians.

'A Waste Of Health Care Dollars'

New Hampshire is a full-practice state, but Wendy Wright still encounters federal limits on her scope of practice. Last winter one of her patients, a woman in her seventies, came home from the hospital following a stroke. She had just begun to take a blood-thinner medication to reduce the chances of developing a blood clot. She needed a routine test to determine whether she had the right dose of the medication in her blood but was too sick to drive herself to a doctor.

Wright wanted to send a home health care nurse to the patient's home but couldn't get a physician to sign the certification that Medicare requires. The physician she pays to do certifications was unavailable, and she couldn't find a substitute on short notice. Wright had a full day of patient appointments in her office, and the woman had no way of coming to the office. So less than forty-eight hours after leaving the hospital, a family member was eventually able to drive her to get the blood test. By then it was the weekend and Wright's office was closed, so they went back to the hospital for the test.

"Going to the hospital was more expensive and a waste of health care dollars," Wright says. But more important than the extra cost was the delay that raised the patient's risk of bleeding or developing a blood clot if the dosage was wrong, she says.

In another case, she had a patient who had painful diabetic neuropathy in his feet and was barely able to walk. He needed diabetic shoes to protect his feet. Wright says that she manages all of the care for her diabetic patients but can't order diabetic shoes. Under a separate Medicare rule, only a physician can do that.¹⁰

"I had to send this patient out of his home to an endocrinologist," Wright says. He waited four months for the appointment, she says, "only for the endocrinologist to say, 'Yup, you do need those shoes that Wendy thought you needed four months ago.' And then the endocrinologist ordered up the shoes."

Ohio requires nurse practitioners to have a contract with a physician before practicing in the state, and some nurse practitioners pay physicians as much as \$2,000 a month, says Marie Grosh. She remembers a patient who needed wound care at home in Cleveland. His physician wouldn't sign the necessary paperwork without seeing him but also wouldn't visit

the patient at home. The patient had to pay for a temporary ramp so that he could get out of the house in his wheelchair and into an ambulette, which he also paid for.

Becky Bryant is a nurse practitioner in rural southwestern Ohio, where one of her patients waited several days before a physician was available to sign an order for home health care. By that time, the open wound on his hip had doubled in size and deepened. Instead of taking two or three weeks to heal, she says, it took nearly three months.

In Maine, a full-practice state, Donna DeBlois, president of MaineHealth Care at Home, in Saco, says that many of her patients in rural parts of the state get care from small health clinics staffed by advanced practice nurses. They may never have seen a primary care doctor. Maine ranks second—just behind Florida—as the state with largest percentage of residents ages sixty-five and older (10.4 percent). And their number increased 32.4 percent during the ten years ending in 2016.³

DeBlois says that there have been situations where a physician was expected to sign the paperwork but the patient couldn't wait. Her agency provided the care with the understanding that the physician would sign the certification. When the physician later refused, the agency was not paid.

Scope Of Practice

One way to avoid Medicare restrictions is to avoid Medicare: Patients paying for their own home health care out of pocket are not bound by physician or training requirements because Medicare isn't reimbursing them, according to Kate Rolf, president and CEO of Nascentia Health, a home care agency in Syracuse, New York. Such flexibility, however, is available only to patients who can afford it.

But once a home health agency is engaged through Medicare, it faces additional limits. For example, to carry out the patient's plan of care, an agency can arrange for visits from a physical, occupational, or speech therapist or a nurse who can provide wound care, replace catheters, administer medications, or check a recent surgical site. The agency can also arrange for home care or personal care aides who help with daily activities such as bathing, dressing, and eating. But the moment these various providers enter the picture and Medicare foots the bill, they are subject to separate scope-of-practice rules that vary from state to state. In Maine, for example, explains Donna DeBlois, a physical therapist visiting a patient at home is allowed to perform a "finger stick blood test" to assess blood clotting

levels, and in New York State a home care aide with special training can help a patient take medication.¹¹

In states with less than full-practice authority, state scope-of-practice limits require nurse practitioners to contract with a physician or work as part of a physician practice to provide medical care, whether that care is in a doctor's office, a hospital, or the patient's home.

In Ohio, physicians who have contracts with nurse practitioners review a handful of patient charts and prescription orders annually. But nurse practitioners say that their collaborating physicians rarely see their home care patients and are rarely involved in their treatment.

The administration of President Donald Trump acknowledges that states may be part of the problem, while significantly skipping over the federal government's role. "Government policies have suppressed competition by reducing the available supply of providers and restricting the range of services that they can offer," say officials from the Departments of Health and Human Services, Labor, and Treasury in a letter transmitting to the president their December 2018 report, *Reforming America's Healthcare System through Choice and Competition*.¹² They warn that "reduced competition among clinicians leads to higher prices for health care services, reduces choice, and negatively impacts overall health care quality and the efficient allocation of resources."

Last year the staff of the Federal Trade Commission (FTC) supported a Pennsylvania bill that would allow nurse practitioners to work without a physician's supervision after they had practiced in a collaborative arrangement with a physician for at least three years and 3,600 hours. "Undue regulatory restrictions on APRN practice can impose significant costs on health care consumers—patients—as well as both public and private third-party payors," FTC staff members wrote in response to a state legislator.¹³

Changing The Rules

In February the California Future Health Workforce Commission unveiled a comprehensive study of the state's health care resources. "California does not have enough of the right types of health workers in the right places to meet the needs of its growing, aging, and increasingly diverse population," the commission warned.^{14(p5)}

Among its recommendations were steps to "maximize the role of nurse practitioners as part of the care team to help fill the gaps in primary care."^{14(p7)} The commission echoed similar conclusions of the 2011 landmark Institute of Medicine study titled *The Future of Nursing: Leading*

Change, Advancing Health. The study recommended removing what it called “scope-of-practice barriers” and said that APRNs “should be able to practice to the full extent of their education and training.”¹⁵

Joanne Spetz, a member of the California commission and director of the Health Workforce Research Center for Long-Term Care at the University of California San Francisco, says, “Without fully engaging nurse practitioners, I think it’s very difficult to imagine how we address the increasing demands for the primary care and geriatric services that the aging population needs.”

While nearly half of the states have adopted full-practice rules, legislation pending in California, Ohio, and other states has generated strong opposition from key stakeholders.

“Anyone who has ever been sick or severely injured wants to know that they are under the care of a capable physician,” says Reginald Fields, senior director for external and professional relations at the Ohio State Medical Association. Legislation pending in the Ohio House of Representatives would eliminate nurse practitioners’ physician contract requirement. “Any effort to remove a physician, who is uniquely qualified to provide life-altering care, is a dangerous and unwarranted proposal that is not focused on the best interest of the patient,” he says.

“That does not mean that nurse practitioners, and other medical professionals, should be undervalued, because they, too, play important roles in the delivery of care,” he continues. “But their expertise is most safely applied when used in a team-based approach led by a physician.”

John Cullen, a family physician in Valdez, Alaska, and president of the American Academy of Family Physicians, also says that a team approach, led by a physician, is best.

“What is the problem we’re trying to solve?” he asks. Giving nurse practitioners more independence doesn’t address the underlying issue, which Cullen says is the shortage of primary care physicians. He would like to see an increase in the number of those physicians, especially family medicine providers. Cullen suggests that incentives such as better pay and medical school loan forgiveness would help make primary care more attractive.

“The American Medical Association encourages physician-led health care teams that utilize the unique knowledge and valuable contributions of all clinicians to enhance patient outcomes,” a spokeswoman for the organization says. “Nurses, nurse practitioners, and LPNs [licensed practical nurses] are valuable members of this team, and patients win when each mem-

ber of their health care team plays the role they are educated and trained to play.”

But Sen. Susan Collins, a Maine Republican who grew up in Caribou, a town of about 8,000 residents less than an hour’s drive from the Canadian border, has another idea. She argues that better utilization of nurse practitioners now should be one of the solutions to the shortage of primary care providers, particularly in rural communities. An important first step would be to eliminate the Medicare rule that allows no one but physicians to certify patients for home health care.

“I have learned of far too many cases of seniors experiencing unnecessary delays in accessing home health care because a physician was not available to order the care promptly,” she said in February 2019, when she reintroduced a bill to remove the requirement that a physician—and no one else—must certify that a patient needs Medicare-covered home health care.¹⁶

The legislation, cosponsored by Sen. Ben Cardin (D-MD), would enable physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives to order Medicare-covered home health services.¹⁷ “To avoid these needless delays, it is common sense that other medical professionals who are familiar with a patient’s case should be able to order these services,” Senator Collins noted.¹⁶ In April, Rep. Jan Schakowsky (D-IL) and Rep. Buddy Carter (R-GA) introduced¹⁸ a companion bill in the House of Representatives that has gained bipartisan support.¹⁹

Both bills—known as the Home Health Care Planning Improvement Act—have been endorsed by trade associations that represent nurse practitioners, home care and hospice providers, physician assistants, APRNs, and the AHA’s American Organization of Nurse Executives. AARP, the largest organization of older adults in the country, supports the bill because, among other reasons, making home health care more accessible would provide “the opportunity for family caregivers to find some relief,” says Winifred Quinn, advocacy and consumer affairs director at AARP’s Public Policy Institute.

Senator Collins first introduced the measure in 2007. But the outcome this year might not be any different: The chances of Congress passing the bill are uncertain.

Yet despite the tri-agency federal report that criticized state limits on nurse practitioners as anticompetitive, Medicare officials say that they lack the authority to make home health care more accessible by eliminating the requirement for a physician to sign off. That change depends on Congress enacting a law to do so. ■

The author is grateful for continuing support from a journalism fellowship sponsored by the Gerontological Society of America, Journalists Network on Generations, and the Silver Century

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NOTES

- 1 Choi PA, Xu S, Ayanian JZ. Primary care careers among recent graduates of research-intensive private and public medical schools. *J Gen Intern Med*. 2013;28(6):787–92.
- 2 IHS Markit. 2019 update: the complexities of physician supply and demand: projections from 2017 to 2032 [Internet]. Washington (DC): Association of American Medical Colleges; 2019 Apr [cited 2019 April 29]. Available from: https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf
- 3 Administration for Community Living. 2017 profile of older Americans [Internet]. Washington (DC): Department of Health and Human Services; 2018 Apr [cited 2019 Apr 29]. p. 8. Available from: <https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2017OlderAmericansProfile.pdf>
- 4 The twenty-two states are Alaska, Arizona, Colorado, Connecticut, Hawaii, Idaho, Iowa, Maine, Maryland, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, South Dakota, Vermont, Washington, and Wyoming, plus the District of Columbia. American Association of Nurse Practitioners. State practice environment [Internet]. Austin (TX): AANP; [updated 2018 Dec 20; cited 2019 April 29]. Available from: <https://www.aanp.org/advocacy/state/state-practice-environment>
- 5 Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2019 Mar. Chapter 9, Home health care services; [cited 2019 April 29]. p. 231. Available from: http://medpac.gov/docs/default-source/reports/mar19_medpac_entire_report_sec.pdf?sfvrsn=0
- 6 Glenda Jimmo, et al., on behalf of themselves and all others similarly situated, v. Kathleen Sebelius, Secretary of Health and Human Services. Civil Action No. 5:11-CV-17-CR. Settlement Agreement in the United States District Court for the District of Vermont. 2012 Oct 16.
- 7 CMS.gov. Important message about the *Jimmo* settlement [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [cited 2019 April 30]. Available from: <https://www.cms.gov/center/special-topic/jimmo-center.html>
- 8 Jaffe S. Home care agencies often wrongly deny Medicare help to the chronically ill. *Kaiser Health News* [serial on the Internet]. 2018 Jan 18 [cited 2019 Apr 30]. Available from: <https://khn.org/news/home-care-agencies-often-wrongly-deny-medicare-help-to-the-chronically-ill/>
- 9 Brassard A. Removing barriers to advanced practice registered nurse care: home health and hospice services [Internet]. Washington (DC): AARP Public Policy Institute; 2012 Jul [cited 2019 Apr 30]. p. 3. Available from: https://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/removing-barriers-advanced-practice-registered-nurse-home-health-hospice-insight-july-2012-AARP-ppi-health.pdf
- 10 Medicare.gov. Therapeutic shoes and inserts [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [cited 2019 Apr 30]. Available from: <https://www.medicare.gov/coverage/therapeutic-shoes-inserts>
- 11 Gray RF. Advanced home health aide agency requirements [Internet]. Albany (NY): New York State Department of Health; 2019 Jan 22 [cited 2019 Apr 30]. Available from: https://www.health.ny.gov/facilities/home_care/dal/docs/19-02.pdf
- 12 Department of Health and Human Services, Department of the Treasury, Department of Labor. Reforming America's healthcare system through choice and competition [Internet]. Washington (DC): HHS; [cited 2019 April 30]. p. 3. Available from: <https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf>
- 13 Koslov TI, Vita MG, Hoffman DB. Letter to Jesse Topper, Pennsylvania House of Representatives [Internet]. Washington (DC): Federal Trade Commission; 2018 Jan 3 [cited 2019 Apr 30]. Available from: https://www.ftc.gov/system/files/documents/advocacy_documents/federal-trade-commission-staff-comment-pennsylvania-state-house-representatives-regarding-likely/v180002_ftc_staff_comment_to_pa_state_house_re_house_bill_100_and_aprn-cnps.pdf
- 14 California Future Health Workforce Commission. Meeting the demand for health: final report of the California Future Health Workforce Commission [Internet]. Sacramento (CA): The Commission; 2019 Feb [cited 2019 April 30]. Available from: <https://futurehealthworkforce.org/wp-content/uploads/2019/03/MeetingDemandForHealthFinalReportCFHWC.pdf>
- 15 Institute of Medicine. The future of nursing: leading change, advancing health. Washington (DC): National Academies Press; 2011.
- 16 Collins SM. Floor remarks on the Home Health Care Payment Innovation Act and the Home Health Care Planning Improvement Act [Internet]. Washington (DC): US Senate; 2019 Feb 11 [cited 2019 April 30]. p. 2. Available from: <https://www.collins.senate.gov/sites/default/files/2.11.19%20Home%20Health%20Care%20Bills%20Floor%20Remarks%20.pdf>
- 17 Congress.gov. S.296—Home Health Care Planning Improvement Act of 2019 [Internet]. Washington (DC): Library of Congress; [cited 2019 Apr 30]. Available from: <https://www.congress.gov/bill/116th-congress/senate-bill/296>
- 18 Congresswoman Jan Schakowsky [Internet]. Washington (DC): US House of Representatives; 2019. Press release, Schakowsky, Carter introduce bipartisan legislation to improve Medicare patient access to home health care services; 2019 Apr 9 [cited 2019 April 30]. Available from: <https://schakowsky.house.gov/press-releases/schakowsky-carter-introduce-bipartisan-legislation-to-improve-medicare-patient-access-to-home-health-care-services/>
- 19 Congress.gov. H.R.2150—Home Health Care Planning Improvement Act of 2019 [Internet]. Washington (DC): Library of Congress; [cited 2019 Apr 30]. Available from: <https://www.congress.gov/bill/116th-congress/house-bill/2150?q=%7B%22search%22%3A%5B%22H.R.+2359%22%5D%7D>