

Removing Scope-Of-Practice Barriers for Nurse Practitioners to Improve Access to Primary Care

Executive summary:

The existing primary care system faces imminent challenges as more Americans gain insurance coverage under the Patient Protection and Affordable Care Act (ACA). Current scope-of-practice laws may restrict the use of Nurse Practitioners (NPs) as a means of limiting the burden in this field. This policy analysis provides three recommendations to remove restrictive scope-of-practice laws to approach this problem. This analysis finds that the most politically and technically feasible option is to expand coverage of NP services in public insurance.

Background:

The existing primary care system has been facing strains. One study found that in Massachusetts the average wait time for new patient appointments with primary care physicians is around 39 days and only about half or less of primary care physicians are seeing new patients in 2013.¹ With the average length of a primary care visit around 15 minutes, patients and physicians feel the pressure under time constraint.² Short visits strain the doctor-patient relationship, which is essential for quality care. For example, studies show that less dialogue between patient and doctor increases the odds patients will leave the office frustrated.²

This problem may worsen as millions of consumers who gained health coverage through the ACA begin to seek care—some of whom may have seen doctors rarely, if at all, and have a slew of untreated problems.² This increased coverage may not translate to increased access to services. If health care providers are already at or near capacity, this expansion of public coverage may simply result in longer wait times without actually increasing the amount of health care services patients receive.³ However, evidence shows that if health care providers are able to increase the amount of care they supply, either by increasing their labor supply or changing the way they practice, these negative spillover effects may be at least partially mitigated.³

Expanding the role of NPs in primary care may be a key component of addressing the primary care workforce shortage. According to the American Association of Nurse Practitioners:

NPs are trained to provide a full range of primary, acute and specialty health care services, including diagnostic, treatment, and prescription services. All NPs must complete a master's or doctoral degree program, and have advanced clinical training beyond their initial professional registered nurse preparation.⁴

Upon completion of the graduate program, an NP must become board certified by an accrediting body such as the American Nurses Credentialing Center or American Association of Colleges of Nursing.⁵

State scope-of-practice (SOP) laws determine the range of services NPs can provide and the extent to which they can practice independently.⁵ These laws, which vary state to state, govern the clinical role of NPs by defining the level of required physician oversight. Some states allow NPs to practice independently, while others limit NPs' authority to diagnose, treat and prescribe medications to patients without supervision.⁵ Currently, 22 states and the District of Columbia permit NPs to practice independently, while others require some level of physician oversight.⁷ Two-thirds of states with a shortage of primary care physicians also have restrictive SOP laws, which may be a barrier to increasing access to primary care services through NPs.⁷

Payer policies indirectly influence the services provided by NPs. Such policies include whether NPs are recognized as primary care providers and included by health plans in provider networks and whether NPs can bill and be paid directly.⁵ Medicare, for example, does not permit NPs to conduct assessments to admit the patients to skilled nursing facilities or provide the initial certification for hospice care even though it does authorize them to order skilled nursing care and to serve as attending providers and recertify patients' eligibility.⁶ Medicare indirectly recognizes NPs to certify patients for home health care services by authorizing them to conduct the required face-to-face documentary examinations but still requires a physician to document that the NP completed the certification evaluation.⁶

Restrictive SOP laws in conjunction with strict payer policies limit NPs to working as employees of physician practices, hospitals or other entities rather than in their own independent practices.⁵ Given that NPs gain the necessary skills and qualifications to act similarly to a Primary Care Provider, and because they command lower salaries and can be trained more quickly and at lower cost than physicians⁵, removing some of the barriers that restrict NPs' scope of practice may address some of the growing concerns about access to primary care services. Shifting SOP may give rise to concerns over quality of care. Increasing access to primary care services in the form of reduced wait times will require thoughtful policy changes to protect the quality of care provided.

Evidence:

The literature used to inform this memo were found using searches for key words such as “scope-of-practice” “primary care shortage” and “nurse practitioner scope” on Google Scholar and PubMed as well as keeping up-to-date with news sources such as Politico.

Problem:

Problems arise in the context of societal values, and currently, the ACA places an emphasis on access and quality of health care. According to the Congressional Budget Office, as a result of the ACA, roughly 30 million more people are expected to gain both public and private health insurance coverage by 2015.⁵ Unless there is adequate provider capacity to meet new demand, these coverage expansions will not be equivalent to providing access to services.³ This concern is especially acute for primary and preventive care, as over 57 million Americans live in areas that are deemed by the Centers for Medicare and Medicaid Services to be “primary care health professional shortage areas”.³ According to the Health Resources and Services Administration, to meet a target of one provider for every 2,000 patients, an additional 17,722 primary care practitioners are already needed in shortage areas across the country.⁷ Additionally, an analysis of the aging U.S. population found that another 35,000 to 44,000 adult primary care providers may be needed by 2025.⁷

Studies show that increased insurance coverage expansions cause wait times to increase modestly.³ However, this effect varies significantly across states with different policies towards the provision of non-physician caregivers, with increased wait time concentrated in states with relatively restrictive scope of practice laws.³ In an already strained environment, increased demand for primary care will further restrict access in the form of longer wait times for appointments if the supply of primary care providers response is not great enough to match.

This policy analysis provides three recommendations to remove restrictive scope-of-practice laws to approach this problem. It considers expanding coverage of NP services in public insurance, creating a licensing process to remove SOP barriers, and eliminating SOP laws all together.

Policy Options:

Expand Reimbursement of Public Insurance to Cover NP Primary Care Services

Currently, NP reimbursement varies under Medicare and Medicaid. In Rural Health Clinics, NPs are recognized as primary care providers, operate with an expanded scope of practice and are paid the same rate as physicians.⁵ On the other hand, as previously described, NP service reimbursement under Medicare varies greatly. Revising state regulation of Medicaid managed care plans and federal regulation of Medicare plans may be a more immediate and politically feasible way to expand effective utilization of NPs in primary care.⁵

Public payers can recognize NPs as primary care providers nationally to set a precedent and increase access to services for populations in greatest need of these services. Expanding payment of NPs under Medicaid and Medicare will provide coverage for the millions of Americans living in “primary care professional shortage areas”.³ With more Americans gaining coverage under Medicaid in particular, increasing the supply of providers and reducing SOP laws under public coverage may translate to increased access of services for this population.

Create a Licensing Process to Experienced Veteran NPs to Practice without Restrictions

Unlike physicians, NPs do not undergo a residency program before entering their practice. Generally, NPs are trained to provide services similar to primary care physicians, though they do not complete a post-graduate residency training program.⁵ However, even in restrictive SOP states, most NPs describe having latitude to make clinical decisions, although with a greater level of documented supervision.⁵ Moreover, individual practitioner traits, such as years at the organization or level of experience seem to play an important role in determining everyday practice style and the level of autonomy NPs experience.⁵

Creating a licensing process for experienced NPs to practice without the restrictions of SOP laws can be viewed as a similar training mechanism as physician residency programs. After a set number of years under supervised practice—between 3 and 5 years—an NP will be able to take a licensing exam, similar to primary care physician licensing exams. Passing this exam will give the NP an unrestricted SOP. This mechanism restricts the practicing barriers of NP while still ensuring that they receive adequate supervised training, and therefore may ensure the quality of their care.

Creating an additional licensing exam for NPs on top of their board certification does not completely remove the barrier restricting their scope of practice. It merely adds another hurdle that NPs must pass in order to practice what their training already prepares them to do.

Recognize NPs as Primary Care Providers in All Health Care Plans and Programs⁶

In their training, NPs are given the diagnostic, treatment, and prescribing tools necessary to provide quality care to patients. Therefore, restrictive SOP laws should be completely removed and payers should recognize NPs as primary care providers in all programs and settings.⁶ Given the supply of NPs currently delivering primary care and the shorter time frame required for training new entrants, broadening SOP laws for NPs is a possible avenue to expand primary care capacity more rapidly.⁷ 22

states have already allowed NPs to practice independently while others require some physician oversight for certain services.⁷ Policy should be changed to remove SOP laws in all states.

Restrictive SOP laws are not the only barriers NPs face in practice. Variation in payer coverage of NP services indirectly impacts their ability to provide certain types of care. Eliminating the barrier of SOP laws without addressing the payer issue will not completely address this issue, and since payer practices vary by plan and by state, this option may be less politically and technically feasible.

Recommendation:

Expand Reimbursement of Public Insurance to Cover NP Primary Care Services

Studies suggest that by increasing the ability of providers to meet increased demand, more liberal scope of practice laws mitigate the negative spillover effects associated with large public coverage expansions.³ The positive relationship between coverage expansions and wait times is driven by practices in states where non-physician caregivers cannot directly bill Medicaid.³ In contrast, states where these providers can bill Medicaid directly experience no significant increase in wait time for an appointment.³ These results provide compelling evidence to remove restrictive SOP laws for NPs practicing primary care in order to increase access to these services.

Federal policies mandating recognition of NPs as primary care providers in Medicare plans and State policies mandating recognition of NPs as primary care providers in Medicaid managed care networks could encourage broader and more efficient use of NPs in primary care settings.⁵ Expanding their role in government-regulated services may be more politically and technically feasible, especially in regards to implementation across the nation.

It is recommended that the following actions be taken:

- Expand Medicare reimbursement for NP services provided in primary care settings, providing them with the ability to obtain reimbursement for diagnosing, treating, and writing prescriptions for these patients.
- Expand Medicaid Managed Care reimbursement for NP services provided in primary care settings, providing them with the ability to obtain reimbursement for diagnosing, treating, and writing prescriptions for these patients.
- Provide beneficiaries with information and justification of the policy change.
- Monitor metrics surrounding access and quality as NP scope of practice increases within these plans.

As millions of people gain health coverage under health reform and provider shortages worsen, this policy recommendation has the ability to set a precedent. Previously, Medicare policy changes have acted as a model for change in the private insurance market.² The success of this policy has the ability to spark future discussions to remove these barriers in the private insurance market as well.

Disclaimer: I am a student at Columbia University. However, this comment to the Federal Trade Commission reflects my own personal opinions. This is not representative of the views of Columbia University or the Trustees of Columbia University.

References:

1. MMS Study Shows Patient Wait Times for Primary Care Still Long. *Massachusetts Medical Society*. July 15, 2013. <http://www.massmed.org/News-and-Publications/MMS-News-Releases/MMS-Study-Shows-Patient-Wait-Times-for-Primary-Care-Still-Long/#.U1poq61dVqs>. Accessed April 21, 2014.
2. Rabin R. You're on the clock: Doctors rush patients out the door. *USA Today*. April 20, 2014. <http://www.usatoday.com/story/news/nation/2014/04/20/doctor-visits-time-crunch-health-care/7822161/>. Accessed April 20, 2014.
3. Buchmueller T, Miller S, Vujcic M. How Do Providers Respond to Public Health Insurance Expansions? Evidence from Adult Medicaid Dental Benefits. *National Bureau of Economic Research*. 2014; Working Paper 20053. <http://www.nber.org/papers/w20053>. Accessed April 21, 2014.
4. What's an NP? American Association of Nurse Practitioners Web site. <https://www.aanp.org/all-about-nps/what-is-an-np>. Accessed April 21, 2014.
5. Yee T, Boukus E, Cross D, Samuel D. Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies. *National Institute for Healthcare Reform*. 2013; NIHCR Research Brief No. 13. <http://www.nihcr.org/PCP-Workforce-NPs>. Accessed April 21, 2014.
6. Remove Barriers To Nurse Practitioners' Ability To Practice. American Association of Nurse Practitioners Web site. <https://www.aanp.org/images/documents/federal-legislation/issuebriefs/Issue%20Brief%20-%20Removing%20Barriers.pdf>. Accessed April 21, 2014.
7. Carrier E, Yee T, Stark L. Matching Supply to Demand: Addressing the U.S. Primary Care Workforce Shortage. *National Institute for Healthcare Reform*. 2013; NIHCR Research Brief No. 7. http://www.nihcr.org/PCP_Workforce. Accessed April 21, 2014.