

Wahlstrom
New York

Executive Summary:

Allowing nurse practitioners to provide primary care services may alleviate the strain of the primary care physician shortage on the healthcare system without diminishing the quality of care patients receive (Isaacs & Jellinek, 2012; Lenz et al, 2004). However, federal and state policies restrict nurse practitioners from practicing to the full extent of their training (Robert Wood Johnson Foundation, 2012). To incentivize the use of nurse practitioners in providing primary care services, the Centers for Medicare and Medicaid Services should alter its reimbursement policy to compensate nurse practitioners and physicians at the same rate for equal services (WOCN, 2012).

Problem:

In light of the growing need for primary care services in the U.S., coupled with a shortage in primary care providers, it is important to consider solutions to provide all Americans access to quality, affordable healthcare. Though the issue is complex, it is solvable. Experts suggest changing restrictive SOP laws to allow NPs greater diagnostic and prescriptive responsibilities may alleviate this problem (WOCN, 2012). However, because SOP regulations fall under state jurisdiction, the question remains: How can the federal government incentivize states to alter SOP laws without infringing upon state sovereignty?

Recommendation:

Change Medicare reimbursement mechanisms to disincentivize “incident to” reimbursement. Because Medicare services provided by NPs are reimbursed at 85 percent of the physician fee schedule, health care institutions are incentivized to bill using a physician reimbursement code (WOCN, 2012). This policy can limit the ability of NPs to establish primary care practices, even if doing so is permissible under state law (Yee et al, 2013). The Medicare Payment Advisory Commission recommends Medicare provide equal payment for equal care (Medicare Payment Advisory Commission, 2002). By reimbursing NPs at the same rate as physicians, the Centers for Medicare and Medicaid Services would empower NPs to practice to the full extent of their training and state regulations, thus encouraging -- but not obligating -- states to change SOP regulations.

By providing equal payment for equal service, healthcare institutions in states with less restrictive SOP laws can stop seeking reimbursement through “incident to” payments (WOCN, 2012). Additionally, changing public repayment rates may also change those of private insurers without requiring revision of state laws; in 2008, Massachusetts recognized NPs as primary care providers in both public and private insurance schemes, expanding the number of available PCPs without changing state SOP laws (Institute of Medicine, 2011). Because the policy allows the federal government to encourage the use of NPs as PCPs without demanding states alter SOP laws, this option is more politically feasible than undertaking federal FTC or Department of Justice review of state laws, as some advocacy organizations have recommended (Institute of Medicine, 2011). Rather than incentivizing states to experiment with new methods of delivering care, this policy provides immediate and tangible benefits to providers and their patients.

It is important to underscore that achieving true change in the healthcare system requires collaboration between several stakeholders, including patients, government officials, physicians, nurses, and other health professionals (Institute of Medicine, 2011). The proposed policy does not seek to disempower physicians, but rather to allow all healthcare providers to practice to the full extent of their training, and to provide millions of Americans with access to high-quality, affordable healthcare (Kelly et al, 2013).

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