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Health Policy Brief

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Nurse Practitioners and Primary Care.
Federal and state laws and other policies limit how these professionals can help meet the growing need for primary care.

WHAT'S THE ISSUE?

Nurse practitioners are a type of advanced-practice registered nurse. They are registered nurses who have also obtained a postgraduate nursing degree, typically a master's. So-called scope-of-practice laws in many states give these professionals the ability to perform a wide range of primary care services that may be offered when people make an initial approach to a doctor or nurse for treatment as well as ongoing care for chronic diseases.

With a predicted shortage of primary care as the population grows and as millions of people become newly insured starting in 2014, one proposed solution is to expand the role of nurse practitioners in many more areas of the country, and to allow them to provide a wider range of preventive and acute health care services.

Some physician groups oppose an expansion of nurse practitioners' scope of practice, citing concerns over patient safety. Much of the controversy plays out in state capitals, where medical boards and legislators determine scope of practice for nonphysicians, including nurse practitioners. There are also considerations at the federal level that bear on nurse practitioners' ability to be reimbursed for the care that they provide.

This brief examines the policy proposals for allowing nurse practitioners to practice to their full potential and the accompanying debate.

WHAT'S THE BACKGROUND?

Primary care comprises a broad range of services, including the initial evaluation of new symptoms, ongoing care for chronic diseases, and preventive services such as immunizations or screenings. The increased availability of primary care is associated with lower mortality and with reductions in emergency department visits and hospitalizations.

PROVIDING PRIMARY CARE: Primary care services can be provided by physicians and by a range of nonphysician practitioners, such as physician assistants and nurse practitioners, both of whom have graduate degrees and are authorized to examine, diagnose, and treat patients. Although physician assistants must practice in association with a physician, state law determines whether nurse practitioners can work independently of a physician.

In 2012, 18 states and the District of Columbia allowed nurse practitioners to diagnose and treat patients and prescribe medications without a physician's involvement, while 32 states required physician involvement to diagnose and treat or prescribe medications, or both (Exhibit 1).

Many Americans have insufficient access to primary care. The Health Resources and Ser-

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vices Administration (HRSA)—the federal agency responsible for improving access to health care services for people who are uninsured, isolated, or medically vulnerable—has identified roughly 5,700 geographic areas containing 55 million residents as being Primary Care Health Professional Shortage Areas. These areas would need more than 15,000 additional practitioners to meet the target ratio of one primary care practitioner for every 2,000 residents.

Primary care shortages may increase in the future because of changes in demographics (growth and aging of the US population) and demand because of increased insurance coverage with the full implementation of the Affordable Care Act. Many of the initiatives to improve access to primary care focus on increasing the capacity to provide services by increasing the supply of primary care practitioners, often physicians.

PHYSICIANS AND PRIMARY CARE: For more than a decade, there has been reduced interest in primary care among new medical graduates. There are many reasons for this, including physician payment systems that pay more for specialty care than for primary care. In addition, some observers argue that physicians are overqualified for some of today's primary care work, which can involve routine physical assessments and ongoing care rather than diagnosis and treatment of complex conditions.

Some policy makers want to make primary care more appealing to new physicians by increasing payments for primary care services or by supporting loan forgiveness programs for physicians who practice in underserved areas. However, policies intended to encourage future doctors to specialize in primary care will probably require a long time before having a significant impact on capacity. Even then, there is no guarantee that new primary care physicians will continue to practice in the field. Others believe that the emphasis should be on restructuring the delivery of primary care (see "New Models" below).

NURSE PRACTITIONERS AND PRIMARY CARE: There is a growing body of research demonstrating that patients perceive that receiving primary care and having a usual source of care is more important than who it was that provided these services. Studies comparing the quality of care provided by physicians and nurse practitioners have found that clinical outcomes are similar. For example, a systematic review of 26 studies published since 2000 found that health status, treatment practices, and prescribing behavior were consistent between nurse practitioners and physicians.

What's more, patients seeing nurse practitioners were also found to have higher levels of satisfaction with their care. Studies found that nurse practitioners do better than physicians on measures related to patient follow up; time spent in consultations; and provision of screening, assessment, and counseling services. The patient-centered nature of nurse practitioner training, which often includes care coordination and sensitivity to the impact on health of social and cultural factors, such as environment and family situation, makes nurse practitioners particularly well prepared for and interested in providing primary care.

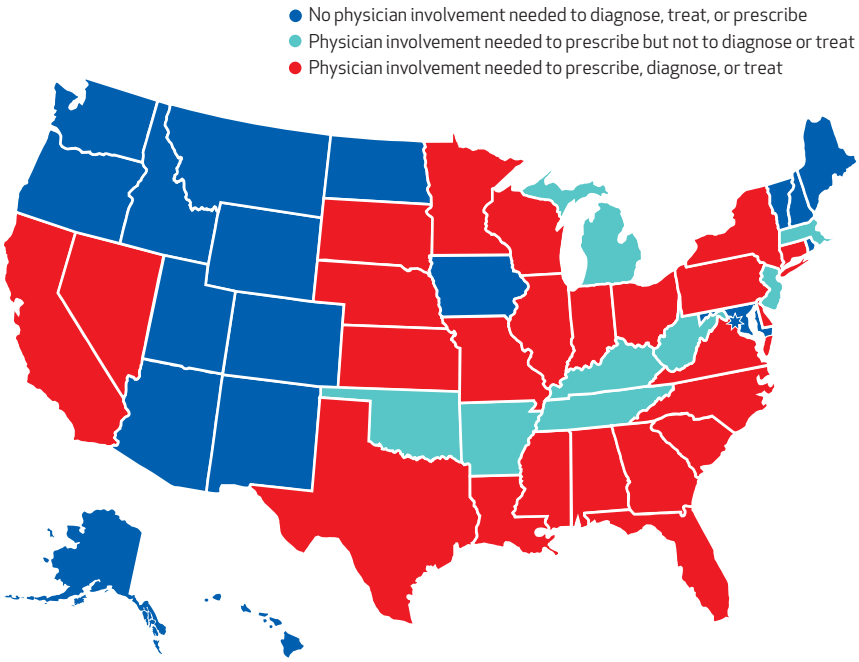
Advocates also note that nurse practitioners could fill the growing primary care shortage more quickly than could physicians, since it takes nurses on average 6 years to complete their education and training, including undergraduate and graduate degrees, compared to an average of 11 to 12 years for physicians, including schooling and residency training.

32

Restrictive jurisdictions
Nurse practitioners need physician involvement to diagnose and treat or prescribe medications, or both, in 32 states.

EXHIBIT 1

Nurse Practitioner Scope-of-Practice Authority, 2012



SOURCE Linda J. Pearson, The 2012 Pearson Report, *American Journal for Nurse Practitioners*. **NOTES** In Connecticut, Indiana, Minnesota, and Pennsylvania, physician involvement is required to diagnose or treat, but written documentation of this is not required. In other states that require physician involvement to diagnose or treat, written documentation is also required.

85%

Medicare payment rate
Medicare pays nurse practitioners practicing independently 85 percent of the physician rate for the same services.

As noted, state scope-of-practice laws determine which functions different professions can perform and in what context. Medical practice acts in every state give physicians full authority to diagnose and treat all conditions. In contrast, nurse practitioner authority varies significantly, with some states allowing nurses to practice independently from physicians, while others require them to be supervised by physicians. Most states fall somewhere in between, requiring nurse practitioners to collaborate with physicians, particularly when prescribing drugs.

Nurse practitioners are nearly always paid less than physicians for providing the same services. Medicare pays nurse practitioners practicing independently 85 percent of the physician rate for the same services. The Medicare Payment Advisory Commission, the federal agency that advises Congress on Medicare issues, found that there was no analytical foundation for this difference. But revising the payment methodology would require Congress to change the Medicare law. Doing so, however, could increase total Medicare spending if increased payment rates are not offset by savings in other areas.

There is evidence that primary care by nurse practitioners is less costly because they tend to order fewer tests and expensive diagnostic procedures than do physicians. Thus, there still may be cost savings from nurse practitioners even if they are paid on a par with physicians for the same services.

In addition, Medicaid fee-for-service programs pay certified pediatric and family practice nurse practitioners directly, but these rates vary by state. Some states pay nurses the same rates as they pay physicians for some or all services, but more than half of the states pay nurse practitioners a smaller percentage of physician rates. The Affordable Care Act provides for enhanced Medicaid payment for primary care services furnished by physicians, and an Institute of Medicine (IOM) report recommended Congress apply those same rates to nurse practitioners providing similar primary care services.

"Patients perceive that receiving primary care and having a usual source of care is more important than who it was that provided these services."

Health insurance plans have significant discretion to determine what services they cover and which providers they recognize. Not all plans cover nurse practitioner services. In addition, many managed care plans require enrollees to designate a primary care provider but do not always recognize nurse practitioners as primary care providers. A survey by the National Nursing Centers Consortium found that in 2009, nearly half of the major managed care organizations did not credential nurse practitioners as primary care providers. Lack of credentialing is cited as a particular problem for Medicare and Medicaid managed care plans, because a growing percentage of the population covered under both programs is enrolled in managed care.

NEW MODELS: Emerging models of primary care emphasize comprehensive, patient-centered care through structures such as patient-centered medical homes and accountable care organizations. These models focus on elements of care such as care coordination and health promotion that have been traditionally provided by nurses.

Programs and funding authorized by the Affordable Care Act support a number of these emerging models, including nurse-led clinics. Nurse-led clinics may provide care in underserved areas or meet the demand for more convenient care by providing a limited number of low-intensity, commonly needed services, in locations such as retail stores. In 2010 HRSA awarded $15 million for a small demonstration project that will support 10 nurse-managed clinics for three years. In addition, the health reform law included $30 million to cover educational expenses to train 600 nurse practitioners and a $200 million clinical training demonstration project designed to increase production of advanced-practice nurses, including nurse practitioners.

WHAT'S THE DEBATE?

Many advocates say changes in federal and state laws are needed to remove barriers to the provision of primary care by nurse practitioners. By contrast, some physician groups are opposed.

OPPOSITION TO EXPANDING NURSE PRACTITIONERS' ROLE: Some physician groups, including the American Medical Association, assert that encouraging patients to see nurse practitioners rather than primary care physicians may put patients' health at risk, although the evidence does not support these claims. They emphasize the difference in education—four years of medical school plus three years of residency for doctors compared to four years of nursing school and two years of graduate school for nurse practitioners. Although these groups acknowledge that nonphysician practitioners, including nurse practitioners, can provide essential patient care, they believe

that such care is most appropriately provided as part of a physician-led team.

PROPONENTS OF EXPANDING NURSE PRACTITIONERS' ROLE: The IOM noted in a 2010 report, *The Future of Nursing: Leading Change, Advancing Health,* that state scope-of-practice laws, and not education and training, dictate the services that nurse practitioners are allowed to perform. The report recommended changes at the state and federal levels to allow nurse practitioners to practice to the full extent of their education.

The IOM recommended specifically that state legislatures reform scope-of-practice laws and regulations to conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules, which outline scopes of practice for advanced-practice registered nurses. It further recommended that state legislatures require fee-for-service plans within the state to similarly cover nurse practitioner services. At the federal level, the IOM recommended that the Federal Trade Commission identify state regulations related to advanced-practice nursing that have an anticompetitive effect without contributing to the health and safety of the public, and that states be urged to change such policies.

PAYMENT REFORMS: The IOM recommended that Congress change the Medicare law to make coverage of nurse practitioner services consistent with coverage of physician services. It further recommended that the Centers for Medicare and Medicaid Services clarify that hospitals participating in the Medicare program must allow nurse practitioners to have clinical and admitting privileges and to be eligible to be on the medical staff. The IOM also endorsed the notion that the federal government should require plans participating in the Federal Employee Health Benefits Program to cover services provided by nurse practitioners operating within state laws.

WHAT'S NEXT?

Concern about access to primary care services will continue to fuel the debate over the role of nursing in delivery of primary care. States will have the opportunity to consider the need for primary care practitioners as they implement provisions of the Affordable Care Act. The National Conference of State Legislatures reports that as of February 2012, 245 bills had been introduced in various state legislatures related to changing scopes of practice. About 50 of these bills would affect nurses, including advanced-practice nurses.

In considering changes to licensure and scope-of-practice requirements, state legislatures will weigh concerns from physicians about patient safety and try to discern whether these concerns have any validity or primarily represent a concern about competition. They will also have to weigh the importance of the need to innovate with new health care delivery models to meet the demand for primary care to a growing and aging population, especially those in need of preventive services at one extreme and those suffering from multiple chronic diseases at the other.■

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