Federal Polices Influence Access to Primary Care and Nurse Practitioner Workforce

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ABSTRACT

Although most nurse practitioners (NPs) are aware of state-level regulations that influence practice, many are unaware of the ways that federal policies affect NP workforce supply and the delivery of primary care. In this investigation we provide an overview of federal initiatives enacted through the Patient Protection and Affordable Care Act that impact the NP workforce. We explore how the law supports NP workforce supply and settings in which NPs provide care. We then describe challenges that may prevent full utilization of the NP workforce. Examining both federal policies and state-level regulations is essential to achieving an increased NP workforce supply and improved access to care.

Keywords: Affordable Care Act, nurse practitioner, policy, workforce

Since the passage of the Patient Protection and Affordable Care Act (ACA),[1] an estimated 11 million individuals have gained access to health care insurance[2] and, as a result of this expanded coverage, primary care visits are expected to increase by 15-24 million annually in the next 5 years.[3] An ongoing shortage of primary care physicians, coupled with the increase in individuals seeking care, raises questions about whether there will be a sufficient supply of providers to accommodate this demand. One proposed solution to addressing the challenge of having enough providers is the use of nurse practitioners (NPs) to provide primary health care to their full capacity.[4] Additional years of education and training enable NPs to function independently, and studies have reported similar—or in some cases better—outcomes for patients treated by NPs compared with physicians.[5-7] However, at this time, barriers exist that prevent NPs from practicing to the full extent of their education and license.[4]

The barrier most commonly cited and discussed among policymakers is the patchwork of state-level regulations governing NP practice.[8,9] Although variations among state laws represent an obstacle to full and efficient utilization of NPs, the workforce is also greatly influenced by federal policies. Understanding how these policies, specifically the ACA, influence the NP workforce and practice has major implications for the delivery of primary care.

In this study we provide an overview of federal initiatives enacted through the ACA that may impact the NP workforce, and ask the following questions: (1) How does the ACA support NP workforce supply? (2) How do federal policies support existing settings and models of care involving NPs? (3) What challenges prevent full utilization of the NP workforce?

Although the policies discussed may impact other advanced practice registered nurses, such as clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists, in this study we focus specifically on the potential impact of these policies on the NP workforce in primary care settings.

ACA AND NP WORKFORCE SUPPLY

Measures in Title V of the ACA support efforts to increase the number of NPs practicing in primary

care settings. Under Section 5509, funding is provided through the Centers for Medicare and Medicaid Services for the Graduate Nurse Education (GNE) demonstration. The GNE demonstration awards up to $200 million in funding to 5 hospital systems from 2012 through 2016 to educate and train greater numbers of NPs. Before implementation of the GNE demonstration, it was widely accepted that many well-qualified NP candidates were being turned away due to insufficient faculty and resources.[10] With implementation of the GNE demonstration, federal funds are now being used by health care systems to reimburse clinical sites and preceptors for time devoted to NP training. GNE sites are expected to increase enrollment across 19 schools of nursing during the 4-year award period.[11]

The ACA has also authorized increased funding to National Health Services Corps (NHSC) programs, which include funds designated for NPs.[12,13] These programs provide financial incentives to those NPs who choose to work in medically underserved areas.[12,13] Over 5 years, through 2015, the ACA has authorized an investment of an additional $1.5 billion to NHSC programs.[14] As a result of this investment, > 1,900 NPs are now practicing in these medically underserved communities.[15] In addition, there has been increased retention of NPs in these settings, with 70% of recipients having chosen to extend their contracts in fiscal year 2013.[16]

ACA AND MODELS OF PRIMARY CARE DELIVERY

Complementary to its efforts to address NP workforce supply, the ACA authorizes increased support for "safety net" health care sites to address access concerns. Federally qualified health centers (FQHCs) and nurse-managed health clinics (NMHCs) are examples of primary care delivery models that support the role of NP practice while providing primary care services.[17,18] Provisions in the ACA authorized $11 billion for FQHCs and $50 million for NMHCs. Support for these sites is particularly important, because, in 2012, FQHCs provided care to > 20 million patients, of whom 36% were uninsured and > 70% were at or below 100% of the poverty level.[19] In addition, it was expected that ACA support to expand NMHCs would allow NPs to treat 94,000 additional patients.[15,20]

The Independence at Home Demonstration, authorized by Section 3024 of the ACA, is an innovative model of care designed to provide home-based primary care services to Medicare beneficiaries.[21] Starting in 2012, this program provides 3 years of funding to 17 sites in an effort to provide high-quality care to those with chronic illness and functional limitations. Although the ACA recognizes NPs as potential leaders of the Independence at Home Demonstration model, it defers to the state to determine whether NPs can lead the team based on scope-of-practice laws.[1]

A third model of care, the Patient-Centered Medical Home (PCMH), is also promoted and supported by the ACA. For fiscal year 2014, the Health Resources and Services Administration (HRSA) awarded $35.7 million to PCMH-designated health centers. These funds will be used to develop and expand primary care services in 147 health centers across the United States.[22] Expanding this model of care has the potential to positively benefit patients' access to quality care, but the federal definition of the PCMH may impose limitations on the NP workforce. At this time, a "personal physician" is the only provider included as a requirement within the ACA's definition of a PCMH.

CHALLENGES

The ACA's authorization of increased funding to support NP education and training, as well as the sites where they practice, offers a viable solution to address workforce supply and patient access challenges. However, the future is by no means secure. There exist several concerns:

1. The GNE demonstration tests an important mechanism to increase the number of NPs; however, funding is not promised beyond 2016.[23] Although there is a strong pool of applicants seeking to become NPs, schools of nursing encounter difficulty securing clinical placements and often lack the resources to compensate clinical practices for productivity losses associated with student precepting.[24] Although the GNE demonstration hopes to address NP workforce supply concerns, results of a full program evaluation will not be available until after its completion,[23] which may

limit future incentive to continue GNE funding. If a model of NP training is not adopted by the Centers for Medicare and Medicaid Services at the conclusion of the GNE, the supply of NPs may be well short of need and demand.

2. Reductions in financial support to FQHCs could limit increased access to care as envisioned by the ACA. Initially, the ACA invested in the support and expansion of FQHCs with establishment of the Health Care Trust Fund (HCTF).[25] Included in the HCTF was a mandatory investment of $11 billion dollars in FQHCs for the fiscal years 2011-2015. These funds were to be applied toward the expansion of existing health care services and the development of new FQHC sites. However, in fiscal year 2011, standing federal appropriations for FQHCs were reduced annually by $600 million (27%) through 2013. This cut in funding necessitated diversion of the new HCTF funds from FQHC expansion to the support of existing FQHC operations. As a result, new development was stalled. If these federal cuts continue through 2015, then almost a third of the funds committed to expanding services will be used to support existing FQHCs.[25]
3. Access to care may also be limited with cuts in funding to NMHCs. Although the ACA originally authorized $50 million for the support and expansion of NMHCs, only $15 million was actually appropriated and divided across 10 NMHCs.[26] This funding occurred only once in 2010, and, in an effort to decrease overall federal spending, the program has not been renewed.[20,27] The importance of ACA funding for NMHCs is underscored by the reality that many NMHCs are either independent nonprofits or operated by schools of nursing.[18] As a result, NMHCs are often unable to receive federal grants, such as FQHC funding.[28] Thus, without a stable source of funding, many NMHCs have had to close.[18] NMHCs will struggle to maintain their status as reliable sources of health care services if current funding challenges persist.[28] In addition to limiting patient access, these reductions in support have implications for the NP workforce. NMHCs serve as valuable primary care clinical training sites for NP students and also provide employment opportunities through placement of providers in underserved areas.[27,28]
4. According to the ACA, a primary care provider (PCP) refers to: "a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services…, developing sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority."[1(p650)]

The language utilized by the ACA confers the title of PCP to any clinician performing this set of proscribed duties; however, the law defers to state regulations as the authority to designate whether NPs can serve in this capacity. By placing the designation of PCP in the hands of state legislatures, the ACA does not address the inconsistencies in state regulations surrounding the NP's scope of practice. Thus, NPs may struggle to provide care to their full potential due to practice restrictions imposed by state governments. This failure of the ACA to recognize NPs as potential PCPs may lead to decreased opportunities for efficient use of the NP workforce in primary care models, such as the Independence at Home Demonstration program and PCMHs.

FUTURE OUTLOOK

Despite the challenges outlined, there are reasons for cautious optimism. Current estimates demonstrate that the NP workforce has grown rapidly in recent years,[29] and is expected to double between 2008 and 2025.[30] NPs represent a significant and increasing source of primary care in the US, with almost 1 in 5[31] of the 192,000 licensed NPs in the US[32] working in primary care. However, sustained federal support for programs such as the GNE and NHSC must continue in order to meet the projected increase in primary care demands.

NPs have historically been active in the delivery of primary care services, and consistent funding of sites where NPs provide care is of critical importance.

Models such as the Independence at Home Demonstration and PCMHs represent innovative approaches to primary care delivery. Without expanded and continued funding, these sites of care and innovative models are at risk of termination, which would limit patient access to necessary care services. In addition, a reliable source of funding for FQHCs and NMHCs is also necessary considering their long-standing provision of health promotion and disease prevention services to patients in medically underserved areas.

Finally, although scope-of-practice barriers are actively being removed in many states, practitioners must be aware of the interplay between federal-level policies and state-level scope-of-practice restrictions. Federal efforts to improve access to primary care services may do well to consider levers that include offering incentives to states that implement scope-of-practice regulatory reform.

CONCLUSION

The goals of the ACA to increase access to primary care services are linked to efficient use of NPs as care providers. These goals rely on federal initiatives and reliable funding to support NP training and education as well as models of care where NPs practice. However, the full benefit of federal efforts may be hampered by restrictions occurring at the state-level, including scope-of-practice barriers. Examining federal policies in tandem with state-level regulations is essential to achieving increased NP workforce supply and improved access to care. JNP

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