Federal Polices Influence Access to Primary Care and Nurse Practitioner Workforce

J. Margo Brooks Carthon, PhD, APRN, Hilary Barnes, PhD, CRNP, and Danielle Altares Sarik, MSN, CRNP

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