

---

November 2015

## Urging a Practical Beginning: Reimbursement Reform, Nurse-Managed Health Clinics, and Complete Professional Autonomy for Primary Care Nurse Practitioners

Joy Luchico Austria

Follow this and additional works at: <https://via.library.depaul.edu/jhcl>



Part of the [Alternative and Complementary Medicine Commons](#), [Bioethics and Medical Ethics Commons](#), [Health Law and Policy Commons](#), [Other Nursing Commons](#), and the [Public Health and Community Nursing Commons](#)

---

### Recommended Citation

Joy L. Austria, *Urging a Practical Beginning: Reimbursement Reform, Nurse-Managed Health Clinics, and Complete Professional Autonomy for Primary Care Nurse Practitioners*, 17 DePaul J. Health Care L. (2015) Available at: <https://via.library.depaul.edu/jhcl/vol17/iss2/3>

This Article is brought to you for free and open access by the College of Law at Via Sapientiae. It has been accepted for inclusion in DePaul Journal of Health Care Law by an authorized editor of Via Sapientiae. For more information, please contact [digitalservices@depaul.edu](mailto:digitalservices@depaul.edu).

**URGING A PRACTICAL BEGINNING:  
REIMBURSEMENT REFORM, NURSE-MANAGED HEALTH  
CLINICS, AND COMPLETE PROFESSIONAL AUTONOMY  
FOR PRIMARY CARE NURSE PRACTITIONERS**

*Joy Luchico Austria, R.N., B.S.N*

**INTRODUCTION**

Florence Nightingale ushered in the modern age of nursing in the mid-nineteenth century during the Crimean War. She set the standard for the profession that we still follow today: compassion, commitment to patient care, and thoughtful hospital administration. Even in the face of professional adversity Nightingale said, “. . . I never lose an opportunity of urging a practical beginning, however small, for it is wonderful how often in such matters the mustard seed germinates and roots itself, and at last produces an overshadowing tree.”<sup>1</sup>

Access to health care is the great challenge for health care reform in the United States. As the primary care physician work shortage continues, policymakers look to midlevel providers, such as nurse practitioners, to fill the gap in care. But to meet the demand for primary health care providers, especially in underserved communities, primary care nurse practitioners should be professionally and financially independent of other health care professionals. Scope-of-practice laws address the capacity for healthcare professionals to exercise independent judgment in clinical patient management. Broad scope-of-practice laws are necessary but not sufficient. Inadequate reimbursement practices threaten the financial viability of clinics and practices operated solely by primary care nurse practitioners. Using nurse-managed health clinics as an example, this article will attempt to show how inadequate reimbursement practices, perhaps more so than scope-of-practice laws, restrain primary care nurse practitioners from complete professional autonomy and hinders access to health care.

Part I is a general overview of the primary care provider shortage and how primary care nurse practitioners can step in to fill the workforce gap. Part II surveys the scope-of-practice laws and reimbursement prac-

---

<sup>1</sup> FLORENCE NIGHTINGALE ON SOCIAL CHANGE IN INDIA 390 (GÉRARD VALLÉE ed. 2007).

tices that restrain nurse practitioners. Part III argues complete professional autonomy for primary care nurse practitioners will not come without reimbursement reform and uses nurse-managed health clinics to illustrate the impact current reimbursement practices have on the financial autonomy of primary care nurse practitioners and nurse-led businesses. Finally, Part IV suggests potential options for reimbursement reform that would offer primary care nurse practitioners financial independence, sustain primary care nurse practitioner operated businesses, and preserve access to health care for underserved communities.

## I. OVERVIEW

### *A. Shortage of Providers in the Primary Healthcare Market*

The United States has a primary care provider workforce shortage that will not likely get any better without intervention. Aging and population growth account for 81 percent of the change in demand from 2010 to 2020.<sup>2</sup> Analysts expect expanded health insurance coverage after the full implementation of the Affordable Care Act to also contribute to an increased demand for primary care services.<sup>3</sup>

Unfortunately that nation's supply of primary care physicians will not rise up to meet this demand. The Health Resources and Services Administration ("HRSA") projected a deficit of 20,400 physicians by 2020.<sup>4</sup> The Association of American Medical Colleges ("AAMC") expects an even larger shortage to the tune of 45,000 physicians by 2020.<sup>5</sup> Moreover the medical school pipeline is drying up. HRSA estimated the number of primary care physicians will increase by a mere 8 percent between 2010 (205,000 FTEs) and 2020 (220,800 FTEs).<sup>6</sup> The National Resident Matching Program reported a slight increase in the number of medical students matching to one of the six areas of primary care: family medicine, family medicine preventative, internal preventative medicine, internal primary medicine, internal pediatrics, and pediatrics primary. In 2014 a total of 1,923 students matched into the primary care specialties; in 2015, that fig-

---

<sup>2</sup> *Projecting the Supply and Demand for Primary Care Practitioners Through 2020*, HEALTH RES. SERVS. ADMIN. (Nov. 2013), <http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/> [hereinafter *HRSA Projecting Supply*].

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> Michael Ollove, *Are There Enough Doctors For the Newly Insured?*, STATELINE (Dec. 30, 2013), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/12/30/are-there-enough-doctors-for-the-newly-insured>.

<sup>6</sup> *HRSA Projecting Supply*, *supra* note 3.

ure increased by 42 students for a total of 1,965 matches.<sup>7</sup> Primary care made up 11.6% of matches in 2014 and 2015.

Medical students cite income and work-life imbalances as deterrents against specializing primary care. Primary care physicians earn around \$3 million less than specialists.<sup>8</sup> In 2010, family care physicians earned \$173,000 whereas oncologists pulled down \$335,000 while cardiologists went home with \$419,000.<sup>9</sup> Long work hours and night and weekend call also make primary care a less attractive option.<sup>10</sup> Others forgo medicine completely because they do not want to deal with health insurance companies or the risk of liability.<sup>11</sup> One study reported an “alarming level” of burnout among adult primary care physicians.<sup>12</sup> Linda Rosenberg, president of the National Council of Behavior Health believes, “Nowadays the best and brightest are talking about become investment bankers or going off to Silicon Valley.”<sup>13</sup>

The Affordable Care Act (“Act”) sought to alleviate the shortage through recruitment and retention initiatives. Title V § 5301 and § 5503 of the Act increased money for training and educating of the primary care physicians.<sup>14</sup> Sections 5501 and § 1202 increased Medicare and Medicaid payments respectively.<sup>15</sup> Other approaches attempt to make better use of all members of the primary care workforce. Bodenheimer suggested solutions to the shortage without training more physicians. His “five-wedge” transformation involves sharing care responsibilities between clinicians, nonclinicians, and nonlicensed personnel; patient self-care; and technology.<sup>16</sup> And since the 1960’s scholars and policymakers alike have advocated the use of midlevel providers, such as nurse practitioners, to fill the primary care provider gap.

### *B. A Viable Option to Fill the Gap: Primary Care Nurse Practitioners*

---

<sup>7</sup> *Advance Data Tables 2015 Main Residency Match*, The Nat’l Resident Matching Program (Mar. 20, 2015), [www.nrmp.org](http://www.nrmp.org).

<sup>8</sup> Ollove, *supra* note 6.

<sup>9</sup> Laura Tobler, *A Primary Problem: December 2010*, NAT’L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/research/health/a-primary-problem.aspx> (last visited Apr. 13, 2015).

<sup>10</sup> Ollove, *supra* note 6.

<sup>11</sup> *Id.*

<sup>12</sup> TD Shanafelt et. al., *Burnout and satisfaction with work-life balance among US physicians relative to the general US population*, 18 ARCHIVES INTERNAL MEDICINE 64-74 (2012).

<sup>13</sup> Ollove, *supra* note 6.

<sup>14</sup> Patient Protection and Affordable Care Act P.L. 111-148, (Mar. 23, 2010).

<sup>15</sup> *Id.*

<sup>16</sup> Thomas S. Bodenheimer & Mark D. Smith, *Primary Cares: Proposed Solutions to the Physician Shortage Without Training More Physicians*, 32 HEALTH AFF. 1881, 1882 (2013).

Primary care nurse practitioners are capable of filling gap. First, the supply of primary care nurse practitioners will likely meet the demand for primary health care services. Second, primary care nurse practitioners are substitutable for physicians because the quality of care is the same for both professions. Finally, changes to the primary care delivery model, where nurse practitioners play a more active and integral role, could alleviate workforce shortage projections.

HRSA projects the primary care nurse practitioner workforce will grow more rapidly than the physician supply.<sup>17</sup> Analysts expects the supply of primary care nurse practitioners to increase by 30 percent between 2010 (55,400) and 2020 (72,100).<sup>18</sup> HRSA reported in 2012 that nearly half (48.1%) of the 127,000 nurse practitioners that provide direct patient care in the workforce specialize in primary care.<sup>19</sup> A report issued by the American Association of Colleges of Nursing and the National Organization of Nurse Faculties shows an increase in the number of students specializing in one of the four areas of primary care: family, adult/gerontology, women's health, and pediatrics.<sup>20</sup> Primary care made up 85 percent of the total number of nurse practitioner graduates in 2013.<sup>21</sup> The number of primary care nurse practitioner that graduated in 2013 (13,568) increased by 1,804 graduates from 2012 (11,764).<sup>22</sup>

But the positive gains in the supply of primary nurse practitioners might not be enough to fill the gap. The total ratio of primary clinicians to population is likely to fall by 9 percent from 2005 to 2020.<sup>23</sup> Moreover, a recent study found the increase in primary care nurse practitioners (and physician assistants) had a minimal impact on the overall health care market.<sup>24</sup> The author observed modest gains in consumer use of nurse practitioner services, access to care, and use of preventative health care services from the increase in the supply of midlevel providers.<sup>25</sup> The study, also found no evidence that an increase in provider supply decreased prices even in states with favorable regulatory environment for nurse practition-

---

<sup>17</sup> *HRSA Projecting Supply*, *supra* note 32.

<sup>18</sup> *Id.*

<sup>19</sup> See Nat'l Ctr. for Health Workforce Analysis, *supra* note 10 at 6.

<sup>20</sup> D. Fang et al., *2013-2014 Enrollment and Graduations*, AM. ASS'N. COLL. NURSING (2014), available at <http://c.ymcdn.com/sites/nonpf.site-ym.com/resource/resmgr/Docs/NPTables2013-2014.pdf>.

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> Bodenheimer & Smith, *supra* note 17 at 1881.

<sup>24</sup> Kevin Stange, *How does provider supply and regulation influence health care markets? Evidence from nurse practitioners and physician assistants*, 33 J. HEALTH ECON. 1-27 (2014).

<sup>25</sup> *Id.* at 2.

ers.<sup>26</sup> However, the author proposed reimbursement policies as one of three reasons for the market's anemic response to the increase in primary care midlevel providers.<sup>27</sup> Rigid reimbursement schemes limit the efficient substitution between providers, preventing cost and price reductions and use increases from materializing.<sup>28</sup> Bear in mind this study was the first of its kind in measuring the effects of increased supply of midlevel providers on the market.<sup>29</sup> The author notes the reasons underlying the lack of market response to an increase in supply remains unanswered and a "fruitful area for further exploration."<sup>30</sup>

Even if an increased supply of nurse practitioners will not fill the gap, primary care nurse practitioners remain a practical substitution for physicians because the quality of care is no different between the two professions. Physicians groups continue to decry the quality of care patients can expect from nurse practitioners.<sup>31</sup> Some insurers still assume nurse practitioners are the primary care providers of "last resort" because nurse practitioners are somehow inferior to physician providers.<sup>32</sup> But research findings report no differences in the quality of care or patient outcomes between nurse practitioners and physicians.<sup>33</sup> In fact, "states with broader scope-of-practice laws have experienced no deterioration of care."<sup>34</sup> Furthermore, patients report higher levels of satisfaction from their interactions with nurse practitioners.<sup>35</sup> A 2002 report found that nurse-managed health centers had a higher retention rate of patients than physician-managed health centers.<sup>36</sup>

A combination of legal and self-governing mechanisms regulates quality of care provided by nurse practitioners. Nurse practice acts are the

---

<sup>26</sup> Strange *supra*, at 2.

<sup>27</sup> *Id.* at 16

<sup>28</sup> *Id.*

<sup>29</sup> *Id.* at 2.

<sup>30</sup> *Id.* at 16.

<sup>31</sup> Stephan Issacs & Paul Jellinek, *Accept No Substitute: A Report on Scope of Practice*, THE PHYSICIANS FOUND. (Nov. 2012).

<sup>32</sup> See Tine Hansen-Turton et al., *Insurers' Contracting Policies on Nurse Practitioners as Primary Care Providers: Two Years Later*, 9 POL., POL'Y & NURSING PRAC. 241, 243-44 (2008).

<sup>33</sup> See OFFICE OF TECH.ASSESSMENT, U.S. CONGRESS, HEALTH TECHNOLOGY CASE STUDY NO. 37, PUB. NO. OTA-HCS-37, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE-MIDWIVES: A POLICY ANALYSIS (1986); Mary O. Munding et. al, *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial*, 283 JAMA 59, 66 (2000); Mary D. Naylor & Ellen T. Kurtzman, *The Role of Nurse Practitioners in Reinventing Primary Care*, 19 HEALTH AFFAIRS 893-99 (2010); Julie Stanik-Hutt et. al, *The Quality and Effectiveness of Care Provided by Nurse Practitioners*, 9 J. NURSE PRAC. 492-500 (2013).

<sup>34</sup> See Hansen-Turton, *supra* note 32 at 244.

<sup>35</sup> Tine Hansen-Turton, *The Nurse-Managed Health Center Safety Net: A Policy Solution to Reducing Health Disparities*, 40 NURSING CLINICS N. AM. 729, 734-35 (2005).

<sup>36</sup> See *id.*

primary source of rules governing the nursing profession.<sup>37</sup> The acts define the categories of nurses<sup>38</sup> and conditions for licensure, such as education,<sup>39</sup> accreditation requirements,<sup>40</sup> and continuing education credits to maintain certification and licensure.<sup>41</sup> The acts delineate the scope-of-practice for nurse practitioners including boundaries for prescriptive authority.<sup>42</sup> Finally, nurse practice acts authorize the nursing board, the state medical board, or a combination of the two to promulgate rules and initiate enforcement action against its members.<sup>43</sup>

Like the medical profession, tort law offers legal remedy for negligent conduct by a nurse practitioner. Courts do not hold nurse practitioners to the same standard of care as physicians or registered nurses. Instead, the courts rely on a standard that reflects the nursing profession's intra-professional and administrative standards.<sup>44</sup>

The profession self-governs itself through private accrediting agencies and trade associations such as the American Association of Nurse Practitioners and the American Nurses Association.<sup>45</sup> Entry requirements are strict. The American Nurses Credentialing Center requires individuals to hold a masters, post-masters, or doctorate from an approved program to sit for the national accreditation exam.<sup>46</sup> Acceptance into a graduate program generally requires applicants have a bachelors of science in nursing and hold a current nursing license<sup>47</sup> and some programs require a mini-

---

<sup>37</sup> Lauren E. Battaglia, *Supervision and Collaboration Requirements: The Vulnerability of Nurse Practitioners and Its Implications for Retail Health*, 87 WASH U. L. REV. 1127, 1134 (2010).

<sup>38</sup> 225 ILL. COMP. STAT. 65/50-10 (2012).

<sup>39</sup> 225 ILL. COMP. STAT. 65/50-70 (2012) (stating educational requirement for registered nurses and licensed practical nurses is not satisfied by completion of correspondence course).

<sup>40</sup> 225 ILL. COMP. STAT. 65/65-5(4) (2012) (Nurse practitioners must "[h]ave obtained a graduate degree appropriate for national certification in a clinical advanced practice nursing specialty or a graduate degree or post-master's certificate from a graduate level program in a clinical advanced practice nursing specialty."); see also Michael B. Zand, *Nursing the Primary Care Shortage Back to Health: How Expanding Nurse Practitioner Autonomy Can Safely and Economically Meet the Growing Demand for Basic Health Care*, 24 J.L. & HEALTH 261, 264 (2011)(noting licensure in forty-three states and the District of Columbia require nurse practitioners pass a national board certification exam).

<sup>41</sup> 225 ILL. COMP. STAT. 65/65-60; 65/55-38; 65/60-40 (2012).

<sup>42</sup> See *infra* Section II(A).

<sup>43</sup> Compare OR. REV. STAT. § 678.140 (2012)(state board of nursing has exclusive authority to regulate nurse practitioners) with MD. CODE ANN., HEALTH OCC. § 8-205(a)(3) (LexisNexis 2009)(joint authority shared by the board of nurse and board of medicine) and GA. CODE ANN. § 43-34-26.1 (2012) (board of medicine has exclusive authority to regulate nurse practitioners).

<sup>44</sup> Battaglia, *supra* note 38 at 1151.

<sup>45</sup> *Id.* at 1134.

<sup>46</sup> Family Nurse Practitioner Certification Eligibility Criteria <http://www.nursecredentialing.org/FamilyNP-Eligibility.aspx> (last accessed Apr. 12, 2015).

<sup>47</sup> Graduate FAQ Marcella Niehoff School of Nursing: Do I need to have completed any special course work or degree to apply to your program?, LOYOLA UNIV. CHI. <http://www.luc.edu/nursing/admission/gradadmission/gradfaqs/>(last accessed Apr. 12, 2015).

num of six months of experience<sup>48</sup> Graduate school prepares nurse practitioners to “*identify* a disease or condition by a scientific evaluation of physical signs, symptoms, history, laboratory tests results, and procedures.”<sup>49</sup> The curriculum requires a class in primary health care and advance courses in pathophysiology, pharmacology, and health assessment. The National Task Force on Quality Nurse Practitioner Education recommended a minimum of 500 hours of supervised direct patient care.<sup>50</sup> Education and training generally takes about six years – four years to earn a bachelors of science in nursing<sup>51</sup> and two-to-four years of graduate school to earn a master of nursing or a doctorate of nursing practice.

Finally, the primary care physician shortage could be alleviated with better use and effective integration of nurse practitioners into the health care delivery system. A surplus of nurse practitioners and physicians assistants could accumulate by 2025 because of rapid growth of both professions but limited use in the primary care setting.<sup>52</sup> Plausible shifts in the primary care delivery model, where nurse practitioners play a more active role and team-based practice is expanded, could alter those projections.<sup>53</sup> Nurse-managed health is one such delivery model.

Nurse-managed health clinics (“NMHC”) have a historic mission to treat underserved populations and are often described as a “safety net” in the health care delivery system.<sup>54</sup> Care is holistic and inter-disciplinary with an emphasis on disease prevention, wellness, and a focus on the family and the community. Staff customizes clinic services to meet the needs of the community.<sup>55</sup> For instance, the Louis and Anne Green Memory and Wellness Center, associated with Florida Atlantic University, serves patients with Alzheimer’s disease and other similar dementias.<sup>56</sup> The center offers counseling services and support groups to family members and oth-

---

<sup>48</sup> Rush University Family Nurse Practitioner FAQ How much experience do I need? [http://www.rushu.rush.edu/servlet/Satellite?c=content\\_block&cid=1320160587734&pagename=CollegeOfNursing%2Fcontent\\_block%2FContentBlockDetail&rendermode=previewnoinsite#6](http://www.rushu.rush.edu/servlet/Satellite?c=content_block&cid=1320160587734&pagename=CollegeOfNursing%2Fcontent_block%2FContentBlockDetail&rendermode=previewnoinsite#6) (last accessed Apr. 12, 2015) (stating competitive applicants have been practice for at least two years).

<sup>49</sup> DOUGLAS M. ANDERSON, MOSBY’S MEDICAL NURSING & ALLIED HEALTH DICTIONARY 80 (2002) (emphasis added). (stating a secondary definition for “diagnosis” is “the art of naming a disease or condition.”)

<sup>50</sup> National Task Force on Quality Nurse Practitioner Education, *Criteria for evaluation of nurse practitioner programs*, AM. ASSOC. OF COLLS. NURSING (2012), available at <http://www.aacn.nche.edu/education-resources/evalcriteria2012.pdf>.

<sup>51</sup> Alternatively, students with a previous bachelors degree in a different field or students with a two year associates degree in nursing may enroll in a two year accelerated bachelors of science in nursing program.

<sup>52</sup> David I. Auerback et al., *Nurse-Managed Health Centers and Patient-Centered Medical Homes Could Mitigate Expected Primary Care Physician Shortage*, 32 HEALTH AFF. 1933, 1938-40 (2013).

<sup>53</sup> *Id.* at 1940.

<sup>54</sup> Nat’s Nursing Ctrs. Consortium, *About Nurse-Managed Care*, [www.nncc.us/site/about-nurse-managed-care](http://www.nncc.us/site/about-nurse-managed-care) (last visited Feb. 19, 2015).

<sup>55</sup> *Id.*

<sup>56</sup> Ruth M. Tappen & Kathleen Valentine, *Building and Sustaining a Caring-Based Nurse-Managed Center*, 2014 PA. NURSE 16, 17.

er caregivers. The Integrated Health Center, a nurse managed faculty practice at the University of Illinois at Chicago, serves patients with severe and persistent mental illnesses.<sup>57</sup> All age groups are seen, but a majority of the patient population consists of middle-aged African-American adults living in medically underserved areas of Chicago.

Nurse practitioners in NMHCs play a principle role in direct patient care and administrative functions. Additional providers, usually volunteers, assist with care management, patient care, and other services: registered nurses, clinical nurse specialists, nurse midwives, public health nurses, community outreach workers, health educators, and collaborating physicians.<sup>58</sup> In the NMHC setting, nurse practitioners may also function as educators and mentors for a wide range of healthcare providers. NMHCs associated with nursing schools serve as a clinical site and training ground for undergraduate nursing students, nurse practitioners, nursing administration students, pharmacists, social workers, physician assistants, and physicians.<sup>59</sup>

Cost per visit is slightly more expensive than care at a physician's practice. One study found the average charge per patient encounters could be \$41.86, \$70.00 if the cost of the patient's medicine was included.<sup>60</sup> The cost of a physician's visit was \$38. However, like many NMHCs the clinic was not operating at total maximum capacity. Direct cost per patient with and without medications would be \$21.13 and \$15.97 respectively had patient volume reached capacity. Nevertheless, a visit to the NMHC was less than a visit to the emergency room (\$713).<sup>61</sup>

Despite cost, research has shown NMHCs have positive impact on individuals and the community. Patients were satisfied with the care they received. "Indicators of quality of care included removing barriers to care, improving health care access, and developing relationships with nurse practitioners."<sup>62</sup> NMHCs also improved use of preventative services, aid in the promotion of health, compliance with treatment, and reduced emer-

---

<sup>57</sup> Marlene Sefton, Emily Brigell, Charlie Yingling & Judy Storfjell, *A journey to become a federally qualified health center*, 23 J. AM. ACAD. NURSE PRAC. 346 (2011).

<sup>58</sup> See Hansen-Turton, *supra* note 33 at 242.

<sup>59</sup> Rebecca E. Sutter-Barrett, Caroline J. Sutter-Dalrymple & Kathleen Dickerman, *Bridge Care Nurse-managed Clinics Fill the Gap in Health Care*, 11 J. NURSE PRAC. 262, 263 (2015).

<sup>60</sup> See R.M. Saywell et al., *A cost analysis of a nurse-managed, voluntary community health clinic*, 25 J. NURSING ADMIN. 17-27 (1995); see also Jennifer L. Coddington & Laura P. Sands, *Cost of Health Care and Quality Outcomes of Patients at Nurse-Managed Clinics*, 26 NURSING ECON. 75, 80 (2008) (reviewing the literature to gather evidence about the quality and cost of providing care in NMHCs).

<sup>61</sup> Agency Healthcare Res. & Quality, *Emergency Room Services-Mean and Median Expenses per Person with Expense and Distribution of Expenses by Source of Payment: United States, 2012*, [http://meps.ahrq.gov/mepsweb/data\\_stats/MEPS\\_topics.jsp?topicid=5Z-1](http://meps.ahrq.gov/mepsweb/data_stats/MEPS_topics.jsp?topicid=5Z-1).

<sup>62</sup> Jennifer L. Coddington & Laura P. Sands, *Cost of Health Care and Quality Outcomes of Patients at Nurse-Managed Clinics*, 26 NURSING ECON. 75, 81 (2008).

gency room visits and re-hospitalizations.<sup>63</sup> Moreover, NMHCs might have a larger impact on the entire healthcare delivery system by diminishing provider imbalances with even a modest increase in the number of clinics since NMHCs “. . . relies almost exclusively on nurse practitioners instead of physicians and physician assistants.”<sup>64</sup>

Yet in 2012 HRSA estimated private physician offices employed about a third of nurse practitioners working in the ambulatory care setting while a mere 4.1% of nurse practitioners practiced in a private nurse practitioner office, 2.9% worked at a community clinic, and 2.2% were employed by a retail based clinic.<sup>65</sup> Despite the promise of nurse practitioners filling the primary care provider gap, several forces hamstring them from independently practicing to the full extent of their education, training, and experience.

## II. Restraints on Primary Care Nurse Practitioner Operated Clinics

Restraint of trade is “a limitation on business dealings or professional occupations . . . intended to eliminate competition, create monopolies or otherwise adversely affect the free market.”<sup>66</sup> Nurse practitioners contend that the medical community has made a concerted effort to limit their professional occupation and business dealings. Physicians have been especially vocal about the need to restrain nurse practitioners from independent practice.<sup>67</sup> Doctors argue their intentions are to protect the public from the unauthorized practice of medicine.<sup>68</sup> However, physicians are keenly aware that nurse practitioners and other midlevel providers threaten the medical establishment’s financial dominance over the primary care market.<sup>69</sup> Nurse practitioners’ autonomy has been restrained on two fronts. First, regulatory policies permit other health care professions to interfere with nurse practitioners’ ability to manage patients. Second, public and private reimbursement practices endanger the financial independence of clinics run by nurse practitioners.

---

<sup>63</sup> *Id.* at 85.

<sup>64</sup> Auerback, *supra* note 53 at 1939.

<sup>65</sup> See Ctr. for Health Workforce Analysis, HIGHLIGHTS FROM THE 2012 NATIONAL SAMPLE SURVEY OF NURSE PRACTITIONERS 8 (2014).

<sup>66</sup> BLACK’S LAW DICTIONARY (9th ed. 2009), available at Westlaw.

<sup>67</sup> Rebecca J. Patchin, *AMA Responds to IOM Report on Future of Nursing* (Oct. 5, 2011), <http://www.ama-assn.org/ama/pub/news/news/nursing-future-workforce.page>.

<sup>68</sup> Health Policy Brief, Nurse Practitioners and Primary Care (Oct. 25, 2012) [www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=79](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=79)

<sup>69</sup> Issacs & Jellinek, *supra* note 32 at i-ii.

*A. Restraints on Clinical Patient Management: Scope-of-Practice Laws*

“Scope-of-practice regulation focuses on boundary setting between professions.”<sup>70</sup> The dividing line separates what professionals can and cannot practice. At stake, in the case of nurse practitioners and physicians, is the capacity for each profession to direct patient care.<sup>71</sup> This does not mean mere consultations or discussions seeking the learned opinion of another healthcare profession, but rather, the ability to make the ultimate decision when it comes to clinical patient management. Physicians have traditionally held this role; nurse practitioners are asking the states for that same authority. Twenty states and the District of Columbia authorize full professional autonomy for nurse practitioners<sup>72</sup> Nurse practitioners are free to exercise the full extent of their education and training. They evaluate patients, order testing, diagnose diseases, and initiate and manage treatment without supervision from other healthcare professionals.<sup>73</sup>

But a majority of the nation’s nurse practitioner scope-of-practice laws fall into a collaboration and supervision regulatory scheme. Thirty states impose conditions that restrict or reduce at least one element of nurse practitioner practice. Eighteen states require collaboration agreements.<sup>74</sup> To practice, nurse practitioners must develop a set of written pro-

<sup>70</sup> BARRY R. FURROW ET AL., HEALTH LAW 124 (7th ed. 2013).

<sup>71</sup> Furrow rightly points out that “[t]o the extent that [scope-of-practice] regulation depends on identifying discrete activities that “belong” to each profession, it applies a notion that reflects neither the overlapping competencies of health care professionals nor the nature of diagnosis and treatment.” *Id.*

<sup>72</sup> See ALASKA STAT. § 08.68.010 et seq. (2014); ARIZ. REV. STAT. ANN. § 32-1601 et seq. (2014); COLO. REV. STAT. § 12-38-101 et seq. (2014); CONN. GEN. STAT. § 20-87 et seq. (2014); D.C. CODE § 3-1201.01 et seq. (2014); HAW. REV. STATE § 457-1 et seq. (2014); IDAHO CODE ANN. § 54-1401 et seq. (2014); IOWA CODE § 152.1 et seq. (2014); ME. REV. STAT. TIT. 32, §2101 et seq. (2014); MINN. STAT. § 148.171 et seq. (2014); MONT. CODE ANN. § 37-1-3 et seq. (2014); NEB. REV. STAT. § 98-001 et seq. (2014); NEV. REV. STAT. § 632-237 et seq. (2014); N.H. REV. STAT. ANN. § 326-B:1 et seq. (2014); N.M. STAT. ANN. § 63-3-1 et seq. (2014); N.D. CENT. CODE § 43-12.1-01 et seq. (2014); OR. REV. STAT. § 678.010 et seq. (2014); R.I. GEN. LAWS § 5-34-1 et seq. (2014); VT. STAT. ANN. TIT. 26, § 1611-1616 et seq. (2014); WASH. REV. CODE § 18.79.250 (2014); WYO. STAT. ANN. § 33-21-119 et seq. (2014); see also Am. Assoc. of Nurse Practitioners, 2014 Nurse Practitioner Practice Environment (last updated May 13, 2014), <https://www.aanp.org/images/documents/state-leg-reg/stateregulatorymap.pdf> (AANP State Regulatory Map hereinafter).

<sup>73</sup> See AANP State Regulatory Map, *supra* note 53.

<sup>74</sup> See ALA. CODE § 34-21-80 et seq. (2014); ARK. CODE ANN § 17-81-101 et seq. (2014); DEL. CODE ANN. TIT. 24, § 1901 et seq. (2014); 225 ILL. COMP. STAT. 65/50-5 et seq. (2014); IND. CODE § 25-23 et seq. (2014); KAN. STAT. ANN. § 74-60-101 et seq. (2014); KY. REV. STAT. ANN. § 314.193 et seq. (West 2014); LA. REV. STAT. ANN. § 37:911 et seq. (2014); MD. CODE ANN., HEALTH OCC. § 8-101 et seq. (LexisNexis 2014); MISS. CODE ANN. § 73-15-20 et seq. (2014); N.J. STAT. ANN. § 45:11-49 et seq. (West 2014); N.Y. EDUC. § 6902(3)(A) (McKinney 2010); OHIO ADMIN. CODE § 4723-8-04 et seq. (2014) (West); 28 PA. CONS. STAT. § 21.282A (2014); S.D. CODIFIED LAWS § 36-9A-17 THROUGH 17.3 et seq. (2014); UTAH CODE ANN. § 58-31B-102(5-6) (2014); W. VA. CODE § 333.7101 et seq. (2014); WIS. ADMIN. CODE BON § N 8.10(7)(2014); See also AANP State Regulatory Map, *supra* note 53.

protocols with physicians that define the limits of their job. The twelve most restrictive states require direct supervision, delegation, or team-management by an outside health discipline.<sup>75</sup> Moreover, nurse practitioners prescriptive authority varies among the states. While all fifty states authorized some form of prescription authority for nurse practitioners, over half of the states require physician supervision.<sup>76</sup>

Collaboration and supervision laws sound cooperative and benign, but the costs outweigh the benefits. First, collaboration and supervision is an inefficient use of primary care resources. Nurse practitioners are “rendered dependent and subordinate to physicians.” Protocols and supervision prohibit nurse practitioners from making independent decisions for aspects of patient care they were trained and educated to make. The relationship is not one of mere collegial consultation, such as one professional conferring with another about a patient’s medical history or options for treatment. Instead, the law requires nurse practitioners “to seek approval and consent of a physician prior to providing a new type of care or in any other way departing from previously established written protocols.”<sup>77</sup>

Second, collaboration and supervision laws increase labor costs for primary care practices that employ nurse practitioners. Some states enacted maximum oversight rules that set statutory limits on the number of nurse practitioners one physician may supervise at any given time,<sup>78</sup> so clinics that employ more than the statutory threshold must hire additional physicians to maintain compliance with state laws.<sup>79</sup> Such action likely increases provider costs and only adds to the high cost of healthcare. Thus, collaboration and supervision laws could unintentionally decrease access to care.

The current scope-of-practice regulatory scheme runs counter to contemporary health care reform efforts. Concern over the primary care physician shortage prompted nurse practitioner advocates to push for

---

<sup>75</sup> See CAL. BUS. & PROF. CODE § 1480-85 et seq. (West DATE); FLA. STAT. § 464.001 et seq. (2014); GA. CODE ANN. § 43-26-1 et seq. (2014); MASS. GEN. LAWS CH. 244, § 4.01 et seq. (2014); MICH. COMP. LAWS § 333.7101 et seq. (2014); MO. REV. STAT. § 335.011 et seq. (2014); N.C. GEN. STAT. § 90-171.19 et seq. (2014); OKLA. STAT. TIT. 59, § 567.1 et seq. (2014); S.C. CODE ANN. § 40-33-34(D)(1) (2014); TENN. CODE ANN. § 63-7-126 (2014); 22 TEX. ADMIN. CODE § 221.1(12)(2014); VA. CODE ANN. § 54.1-2957 (2014); See also AANP State Regulatory Map, *supra* note 53.

<sup>76</sup> CAL. BUS. & PROF. CODE § 2836.1(d)(2012)(physician supervision required for nurse practitioners to prescribe drugs or devices); see generally Nurse Practitioner Prescribing Authority and Physician Supervision Requirements for Diagnosis and Treatment (2011). THE HENRY J. KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/nurse-practitioner-autonomy/>.

<sup>77</sup> Battaglia, *supra* note 38 at 1138.

<sup>78</sup> CAL. HEALTH & SAFETY § 3836-1(e) (West 2012); GA. CODE ANN. § 43-34-25 (9)(g) (2012); N.Y. § 6902(3)(v) (McKinney 2012); S.D. CODIFIED LAWS § 36-9A-17.1 (2012) (physicians may not collaborate with more than four nurse practitioners).

<sup>79</sup> See Battaglia, *supra* note 38 at 1138.

broader scope-of-practice laws.<sup>80</sup> Moreover, since 2011 the Federal Trade Commission (“FTC”) has supported legislative efforts to reform scope-of-practice laws.<sup>81</sup> The FTC’s comments have consistently argued that scope-of-practice laws have a pro-competitive effect on state health care markets: Broader scope-of-practice laws: (1) improve access to primary care services because it expands the supply of providers; (2) moderate health care costs and prices; and (3) foster innovation in health care delivery.<sup>82</sup> Furthermore, the FTC urged state legislatures to carefully review the growing body of empirical evidence that shows nurse practitioners do not pose a threat to public health and safety.<sup>83</sup>

In sum, narrow scope-of-practice laws limit autonomy for primary care nurse practitioners because it allows physicians to interfere with nurse practitioners’ ability to clinically manage their patients on their own – a skill for which they have earned a graduate degree and advance training to perform. But a separate regulatory scheme would further hinder complete autonomy by restricting financial independence for primary care nurse practitioners.

*B. Restraints on Financial Autonomy: Reimbursement Practices*

Scope-of-practice laws are necessary, but not sufficient. Simply put, scope-of-practice laws do not guarantee financial autonomy for entrepreneurial primary care nurse practitioners. While scope-of-practice might inform reimbursement practices, particularly in the case of third-party payers, the laws have little to do with rates and disbursement practices. The next section summarizes the current state of reimbursement practices

---

<sup>80</sup> Furrow, *supra* note 71 at 123-24.

<sup>81</sup> See Comment from Andrew I. Gavil Director of the Office of Policy Planning et al. to Jeanne Kirkton Mo. House of Representatives (May 5, 2014), <http://www.ftc.gov>; Comment from Andrew I. Gavil Director of the Office of Policy Planning et al. to Kay Kahn Mass. House of Representatives (Jan. 17, 2014), <http://www.ftc.gov>; Comment from Andrew I. Gavil Director of the Office of Policy Planning et al. to Heather A. Sterns Ill. State Senate (Apr. 19, 2013), <http://www.ftc.gov> (warning Illinois Senate Bill 1662, which prohibits CRNAs from treating chronic pain with the use of spinal injections, “threatens to raise costs, limit access, and reduce choices for Illinois patients [that require pain management services]”); Comment from Andrew I. Gavil Director of the Office of Policy Planning et al. to Theresa W. Conroy Conn. State Representative (Mar. 19, 2013), <http://www.ftc.gov>; Prepared Statement of The Federal Trade Commission Staff Before Subcommittee A of the Joint Committee on Health of the State of West Virginia Legislature (Sept. 10-12, 2012), <http://www.ftc.gov>; Comment from Susan S. DeSanti Director of the Office of Policy Planning et al. to Thomas P. Willmott La. State Representative (Apr. 20, 2012), <http://www.ftc.gov>; Comment from Susan S. DeSanti Director of the Office of Policy Planning et al. to Paul Hornback Ky. State Senator (Mar. 26, 2012), <http://www.ftc.gov>; Comment from Susan S. DeSanti Director of the Office of Policy Planning et al. to Rodney Ellis & Royce West Tex. State Senators (May 11, 2011), <http://www.ftc.gov>; Comment from Susan S. DeSanti Director of the Office of Policy Planning et al. to Daphne Campbell Florida House of Representatives (Mar. 22, 2011), <http://www.ftc.gov>.

<sup>82</sup> Comment from Andrew I. Gavil Director of the Office of Policy Planning et al. to Kay Kahn Mass. House of Representatives (Jan. 17, 2014), <http://www.ftc.gov> (last accessed Oct. 11, 2014) at 4-6.

<sup>83</sup> See *id.* at 7-8.

for primary care nurse practitioner services, which are not likely to sustain nurse practitioner-led businesses.

### *1. Medicare*

The federal government granted nurse practitioners provider status in 1979 with the passage of the Balance Budget Act.<sup>84</sup> The Centers of Medicare and Medicaid Services reimburse nurse practitioners or their employers. Two billing options are available under Medicare for nurse practitioners services. First, Medicare directly reimburses nurse practitioners at 85% of the physician fee schedule. The second option is “incident to” billing. Medicare reimburses 100% of the physician fee schedule for services provided by nurse practitioners but charged under a physician’s provider number. To receive full reimbursement for nurse practitioners services, Medicare mandates that: (1) physicians must be on site with nurse practitioners; (2) nurse practitioners are prohibited from performing the initial patient assessment for new patients; and (3) nurse practitioners are prohibited from performing assessments on established patients with new complaints.<sup>85</sup>

Like collaboration and supervision laws, Medicare reimbursement is a false victory. Given that over half of the nation’s nurse practitioner scope-of-practice laws fit into the collaboration and supervision scheme, most primary care nurse practitioner must work for a physician if they want to practice at all. Under the “incident to” scheme physician employers receive Medicare reimbursement for nurse practitioners services *and then* pay nurse practitioners a fixed salary.

Moreover, incident to billing is costly to the primary care system on two fronts. First, “restrictive reimbursement policies thwart efforts to reduce health care costs by creating the necessity for patients to pay for two providers instead of one.”<sup>86</sup> Second, incident to billing further fragments primary care. Incident to billing restricts nurse practitioners from carrying out at least one element of their practice. Even though nurse practitioners have experience performing head-to-toe assessments as a registered nurse and further refined that skill during graduate school, incident to billing insists on prohibiting nurse practitioners from conducting patient assessments on first time clinic patients or for established patients with a

---

<sup>84</sup> Balanced Budget Act of 1997, Pub. L. No. 105-33.

<sup>85</sup> See CTRS. FOR MEDICARE AND MEDICAID SERVS., MLN MATTERS NO.: SE0441, “INCIDENT TO” SERVICES 1-3 (2013), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf>.

<sup>86</sup> Kelly, *supra* note 49 at 208.

new problem. Technically, Medicare expects nurse practitioners to stop in the middle of a routine patient assessment and call in a supervising physician if an established patient complains of a new ache or pain or if his cholesterol results are abnormal. What if the other physicians are busy with another patient or on the phone with a medical resident discussing a complex ICU case? Is the patient expected to stay in the waiting room or reschedule his appointment until a physician becomes available? Increased waiting times and rescheduling appointments might decrease patient satisfaction.

## 2. Medicaid

Medicaid reimburses nurse practitioners in all fifty states and the District of Columbia.<sup>87</sup> The rate of reimbursement is inconsistent and varies from 75% to 100% of the physician fee schedule.<sup>88</sup> “Over 70% of Medicaid enrollees receive their benefits through a managed care insurer.”<sup>89</sup> The remaining enrollees finance their medical care through fee-for-service payments to providers.<sup>90</sup>

## 3. State Insurance Laws

State insurance law does not require insurers to credential nurse practitioners to receive reimbursement for their services.<sup>91</sup> In fact “research indicates that the default for third-party payers is not to allow direct payment.”<sup>92</sup> But according to one research study the number of companies that credential nurse practitioners has increased since 2005 (see Figure 1).<sup>93</sup>

---

<sup>87</sup> Susan A. Chapman et al., *Payment Regulations for Advanced Practice Nurses: Implications for Primary Care*, 11 POL., POL. & NURSING PRAC. 89, 80 (2010).

<sup>88</sup> *See id.*

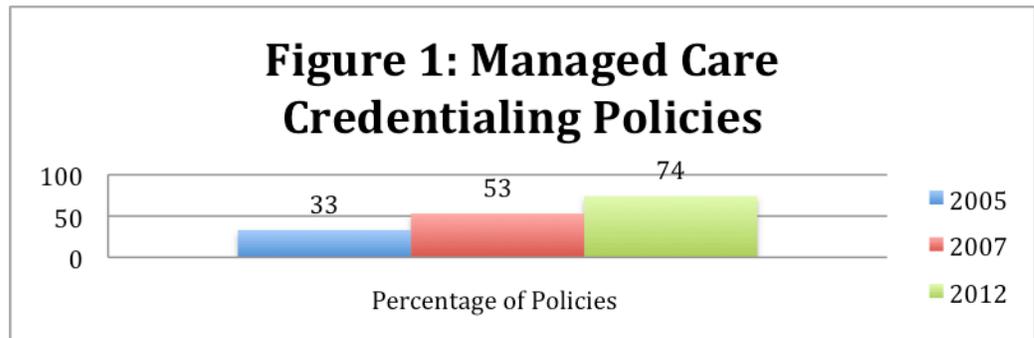
<sup>89</sup> *Id.* at 92 n.5; *see infra* Figure 3.

<sup>90</sup> Chapman, *supra* note 88 at 80.

<sup>91</sup> *See* Tracy Yee et al., *Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies*, in NAT'L INST. FOR HEALTH CARE REFORM at 6, (Research Brief No. 13, 2013), available at <http://www.nihcr.org/PCP-Workforce-NPs>.

<sup>92</sup> *See* Tracy Yee et al., *Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies*, in NAT'L INST. FOR HEALTH CARE REFORM at 6, (Research Brief No. 13, 2013), available at <http://www.nihcr.org/PCP-Workforce-NPs>.

<sup>93</sup> *See* Hansen-Turton, *supra* note 33 at 243; Tine Hansen-Turton et. al., *Are Managed Care Organizations in the United States Impeding the Delivery of Primary Care by Nurse Practitioners? A 2012 Update on Managed Care Organization Credentialing and Reimbursement Practices*, 16 POPULATION HEALTH MGMT. 307, 308 (2013).

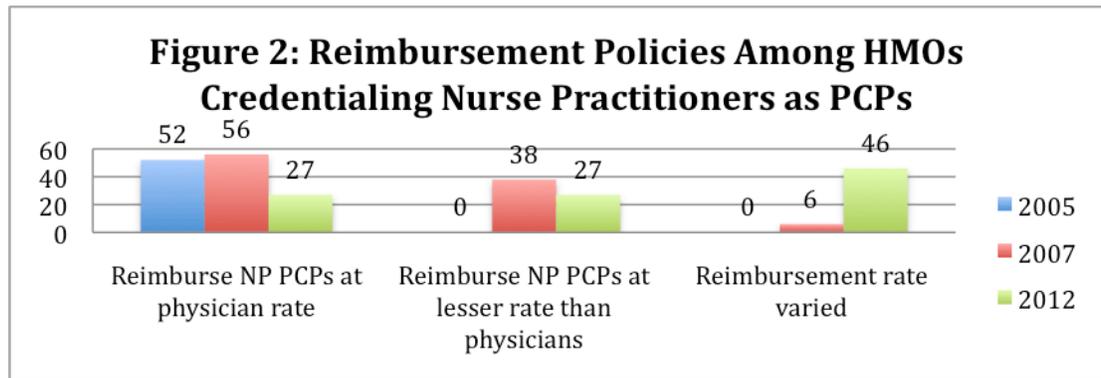


*Source:* Tine Hansen-Turton et al., *Insurers' Contracting Policies on Nurse Practitioners as Primary Care Providers: Two Years Later*, 9 POL., POL'Y & NURSING PRAC. 241, 242 (2008); Tine Hansen-Turton et. al., *Are Managed Care Organizations in the United States Impeding the Delivery of Primary Care by Nurse Practitioners? A 2012 Update on Managed Care Organization Credentialing and Reimbursement Practices*, 16 POPULATION HEALTH MGMT. 307 (2013).

Reimbursement rates for nurse practitioners as primary care providers have traditionally been lower than physicians. Tine Hansen-Turton has been studying nurse practitioners reimbursement since 2005. Based on the HMOs she surveyed, the percentage of policies that reimbursed at physician rates were about the same in 2005 and 2007, but sharply decreased in 2012 (see Figure 2). While the percentage of plans reimbursing at a lower rate than primary care physicians has decreased as well, recent studies suggest reimbursement rates have become increasingly varied, vacillating between equal physician rates to lower rates (see Figure 2). About half the states provide Medicaid fee-for-service pay parity with physicians while “others reimburse between 75% and 95% of physician payment rates.”<sup>94</sup> Commercial plans pay anywhere from 70% to 100% of the physician rate.<sup>95</sup> Payment disbursement is equally scattered. Some plans require direct reimbursement others require payments are made to employers.

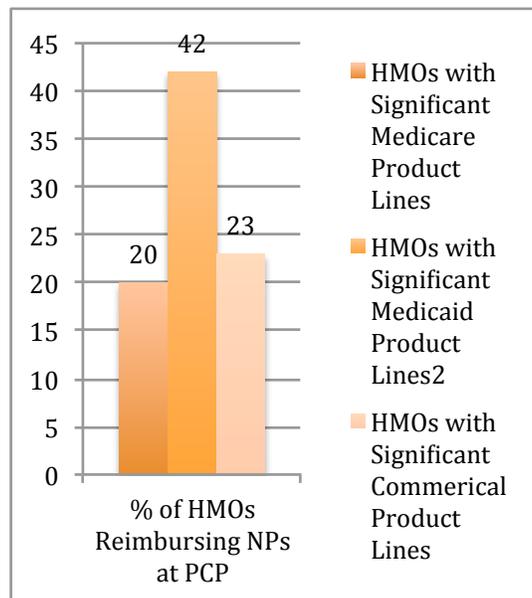
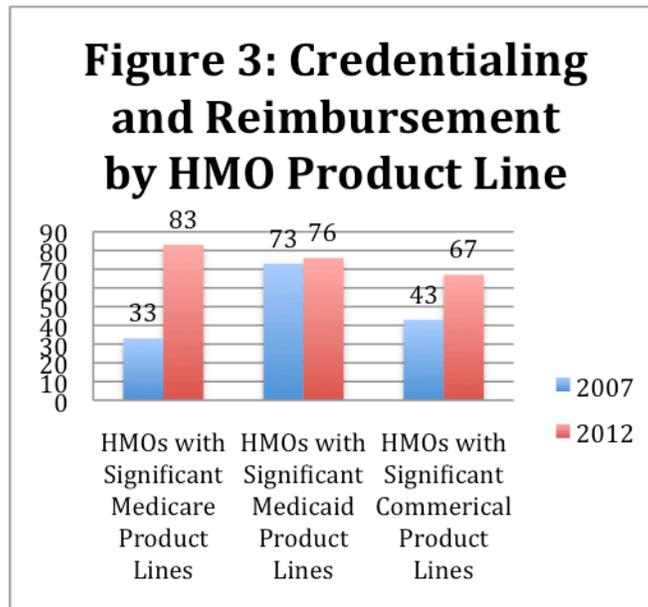
<sup>94</sup> Tracy Yee et al., *Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies*, in National Institute for Health Care Reform at 6, 7 no.12 (Research Brief No. 13, 2013), available at <http://www.nihcr.org/PCP-Workforce-NPs>.

<sup>95</sup> See *id.* at 7 no.13.



*Source:* Tine Hansen-Turton et al., *Insurers' Contracting Policies on Nurse Practitioners as Primary Care Providers: Two Years Later*, 9 POL., POL'Y & NURSING PRAC. 241, 242 (2008); Tine Hansen-Turton et. al., *Are Managed Care Organizations in the United States Impeding the Delivery of Primary Care by Nurse Practitioners? A 2012 Update on Managed Care Organization Credentialing and Reimbursement Practices*, 16 POPULATION HEALTH MGMT. 307 (2013).  
\*2005 data only available for reimbursement of NP PCPs at physician rates.

Hansen-Turton further analyzed the credentialing and reimbursement policies within specific HMO product lines. The percentage of HMOs surveyed show a general increase in credentialing NPs across Medicare, Medicaid, and commercial product lines. But the number of plans that reimburse nurse practitioners at the physicians' rate continues to be low, except for HMOs with significant Medicaid products.



Source: Tine Hansen-Turton et al., *Insurers' Contracting Policies on Nurse Practitioners as Primary Care Providers: Two Years Later*, 9 POL., POL'Y & NURSING PRAC. 241, 242 (2008); Tine Hansen-Turton et. al., *Are Managed Care Or-*

*ganizations in the United States Impeding the Delivery of Primary Care by Nurse Practitioners? A 2012 Update on Managed Care Organization Credentialing and Reimbursement Practices*, 16 POPULATION HEALTH MGMT. 307 (2013).

In sum current reimbursement practices – low rates, inconsistent credentialing patterns – likely deter consumers from seeing primary care nurse practitioners. The next section explores the impact current practices have on nurse practitioner led businesses, using NMHCs as an example.

### III. COMPLETE AUTONOMOUS PRACTICE: REIMBURSEMENT REFORM, FINANCIAL INDEPENDENCE, AND THE LONG-TERM SURVIVAL OF NURSE PRACTITIONER OPERATED BUSINESSES

Current policy efforts to reduce anticompetitive conduct against nurse practitioners have almost exclusively focused on expanding scope-of-practice laws. “Even though research shows a relationship between scope-of-practice laws and the level of autonomy granted to nurse practitioners through public and private payer policies, most nurse practitioners report payer policies had more of an impact than scope-of-practice laws on how and where they can practice.”<sup>96</sup> After all “payers are in a position to determine what services nurse practitioners are paid for, their payment rates, whether nurse practitioners are designated as primary care providers and assigned their own patient panels, and whether nurse practitioners can be paid directly.”<sup>97</sup> As a practical matter, standalone nurse practitioner business cannot survive without a steady source of income.

Granted, untangling scope-of-practice from reimbursement practices is not an easy task.<sup>98</sup> In some respects the problem of complete autonomous practice for nurse practitioners is a chicken and egg conundrum. A 2008 study of managed-care organizations NP reimbursement practices observed a correlation between managed-care organizations credentialing and prescriptive authority laws.<sup>99</sup> The author found 71% of HMOs credentialed nurse practitioners as primary care providers where state law requires *no physician involvement* for nurse practitioners to prescribe medi-

---

<sup>96</sup> Yee, *supra* note 95 at 5.

<sup>97</sup> *Id.* (“Lack of direct payment or low payment rates reportedly discourages many NPs from establishing or leading an independent practice particularly given high overhead and costs associated with investments in electronic health records and other infrastructure.”).

<sup>98</sup> See Yee, *supra* note 95 at 6.

<sup>99</sup> See Hansen-Turton, *supra* note 33 at 246.

caution.<sup>100</sup> On the other hand, payment policies have a significant effect on the de facto scope of practice of nurse practitioners.<sup>101</sup>

Broad scope-of-practice laws may eliminate physician interference into the way nurse practitioners clinically manage their patients, but it does not guarantee financial independence. Even in states with full practice scope-of-practice laws where nurse practitioners are directly compensated for their services, nurse practitioner-led businesses continue to struggle. “Nurse practitioners report that it can be difficult to maintain an adequate volume of patients that are covered by [insurance] plans and whose plans pay at a rate that keeps nurse practitioner practices financially sustainable.”<sup>102</sup> The decision to start a clinic does not turn on whether nurse practitioners could prescribe medication without physician supervision, but rather on whether they could get paid and survive on shoestring budget, or associate with some other entity.<sup>103</sup>

Nurse-managed health clinics are the canaries in the coal mine on this issue. Financial sustainability is well established as the perennial challenge to the survival of NMHC in the primary care market.<sup>104</sup> NMHCs are generally unable to break even and are unprofitable.<sup>105</sup> “Thirty-nine percent of the 70 grantees that received federal funding to establish NMHC from 1993 to 2001 have closed.”<sup>106</sup>

Low patient volume accounts for the poor financial state of NMHCs.<sup>107</sup> Without patients, there is no revenue. Reimbursement plays a role in low turnout. Historically, the target population for NMHCs are the uninsured. Medicaid and Medicare cover about 33% of patients seen in NMHCs and commercial insurance companies cover 28% of patients.<sup>108</sup>

<sup>100</sup> See Hansen-Turton, *supra* note 33 at 246.

<sup>101</sup> Furrow, *supra* note 71 at 131 (7th ed. 2013) (citing California Society of Anesthesiologists v. Superior Court, 204 Cal. App. 390 (2012) (holding the California’s scope-of-practice law permitted nurse anesthetists to opt out of physician supervision as a condition for Medicare reimbursement).

<sup>102</sup> Yee, *supra* note 95 at 6-7.

<sup>103</sup> Laura A. Stokowski, *Healthcare Reform and Nurses: Challenges and Opportunities*, MEDSCAPE (May 6, 2010), <http://www.medscape.com/viewarticle/721049>.

<sup>104</sup> See S. Berger, *Establishing a nursing center: Learning from the literature and the experiences of others*, 11 J. PROF. NURSING 203-212 (1995); Leigh Ann Bonney, Robyn Goetze-Bradley & Kristine Rose, *Process of Developing a College Based Nurse-Managed Clinic Targeting the Underserved Population*, 106 CHART, J. ILL. NURSING 19 (2009); Emily Burke & Erica Schwatz, *Nurse Managed Clinics-Sheridan Health Services a Prime Colorado Model*, 112 COLO. NURSE 1 (2012); Merry J. McBryde-Foster, *Break-Even Analysis in a Nurse-Managed Center*, 23 NURSING ECON. 31 (2005); D. Vincent et al., *A tale of two nursing centers: A cautionary study of profitability*, 17 NURSING ECON. 257-262 (1999).

<sup>105</sup> See Coddington, *supra* note 63 at 80.

<sup>106</sup> Hansen-Turton, *supra* note 33 at 242; see also, S. Barger et al., *Schools with nursing centers: A 5 year follow-up study*, 9 J. PROF. NURSING 9-13 (1993); E.S. King, *A ten-year review of four academic nurse-managed centers*, 24 J. PROF. NURSING 14-20 (2008).

<sup>107</sup> R.M. Saywell, *supra* note 61 at (finding the nurse-managed clinic in the study needed to see 3.5 patients per hour to break even, but the clinic currently saw 1.4 patients per hour).

<sup>108</sup> See R.M. Saywell, *supra* note 61 at (finding the nurse-managed clinic in the study needed to see 3.5 patients per hour to break even, but the clinic currently saw 1.4 patients per hour).

But a majority of patients (40%) seen in an NMHC are uninsured or self-pay.<sup>109</sup> Even with a sliding scale fee structure much of the cost of providing care to the uninsured goes uncompensated.<sup>110</sup> The number of uninsured could potentially increase for two reasons. First, even with full implementation of the Affordable Care Act, 10% of Americans (8% legal residents) will still be uninsured.<sup>111</sup> Second, the expansion of Medicaid failed to expand coverage to the “newly covered” group of people individuals above the poverty level. These individuals are therefore not eligible for tax credits, but are still unable to afford health insurance.

But even if the Affordable Care Act expands insurance coverage for most NMHC clients, low reimbursement rates for nurse practitioner services might actually increase clinic prices. NMHC planners are encouraged to use weighted contribution margins to set price points and more accurately estimate the number of visits needed for the clinic not to lose revenue.<sup>112</sup> Clinic prices are typically set higher than the reimbursement expectations.<sup>113</sup> To calculate the contribution margin, planners should determine the variable costs for each visit, which is dependent on the type of visit billed.<sup>114</sup> The difference between the type of visit billed and variable costs for the visit yield the contribution margin.<sup>115</sup> For NMHC to be profitable, the contribution margin for each visit must be positive.<sup>116</sup> Thus, lower reimbursement rates for primary care nurse practitioner services plus variable costs, could result in higher clinic prices to increase the amount of positive contribution margins coming into the clinic. The final price has the potential to be cost prohibitive for self-payers and may have the potential of being too costly for those with cost-sharing responsibilities through their insurance.

Without a steady stream of revenue, NMHCs typically rely on unreliable outside funding sources. The usual “soft-money” options are available through private grants and charitable donations for money, equipment and space. Government funding at the federal and state level is available, but is unpredictable at best as it requires reliance on the health of the economy, government coffers, and the political atmosphere. State money is available if the budget allows it. As an entity associated with state university, the Louis and Anne Green Memory and Wellness Center

---

<sup>109</sup> Hansen-Turton, *supra* note 33 at 242.

<sup>110</sup> *Id.*

<sup>111</sup> Furrow, *supra* note 71 at 4.

<sup>112</sup> Merry J. McBryde-Foster, *Break-Even Analysis in a Nurse-Managed Center*, 23 NURSING ECON. 31, 34 (2005).

<sup>113</sup> *Id.*

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

<sup>116</sup> *Id.*

in Florida acquired the following state funding options: a matching program for gifts and government appropriations.<sup>117</sup> However, reduced state funds curtailed the matching program. Even though the State designated the Center as one of fifteen memory disorder clinics, the Center did not receive any state fund, because the funding was exhausted after the first thirteen clinics had been funded.<sup>118</sup>

At the federal level, Section 5208 of the Affordable Care Act allocated \$50 million<sup>119</sup> to fund NMHCs. The short-term grant program emphasized the training of nurse practitioners and growing existing NMHCs instead of funding the creation of more clinics outside of academic centers.<sup>120</sup> The program required grant applicants to have an *established* center and prohibited grant money from being used to *construct* new clinics. Preference was given to applicants' affiliations schools of nursing with advanced practice programs<sup>121</sup> and required that at least 30% of the students slots offered at the NMHC reserved for NPs.<sup>122</sup> Finally, the program authorized funds to bring in new staff<sup>123</sup>, but after the grant the clinics still had to contend with funding their new employees' salaries. PPACA's grant program existing NMHCs. For example, the Sheridan Health Services, affiliated at the University of Colorado, originally served pediatric patients<sup>124</sup> used federal grant money to expand service to adults at a new site. The expansion clinic recently uninsured adults lost their jobs to the recession. Despite such goodwill, ultimately the NMHC federal grant did not resolve the long-term survival issues of NMHCs, especially for clinics not affiliated with nursing schools.

This article has attempted to show how inadequate reimbursement practices, perhaps more so than scope-of-practice laws, restrain primary care nurse practitioners from complete professional autonomy. Nurse-managed health clinics could improve access to primary health care. But even with broader scope-of-practice laws, current reimbursement

---

<sup>117</sup> Tappen & Valentine, *supra* note 57 at 17. The initial start-up money was a \$1.5 million gift from a local philanthropist, which the state matched for a total of \$3 million. *Id.* Other donors gave money and the state responded in kind, but eventually the matching program ended because of budget concerns. *Id.* The center twice received earmarks, \$421, 449 and \$987,000 respectively. *Id.* at 17-18.

<sup>118</sup> *Id.* at 20.

<sup>119</sup> See DEPT. OF HEALTH & HUMAN SERVICES., Affordable Care Act (ACA) Nurse-Managed Health Clinics,

<https://www.cfda.gov/index?s=program&mode=form&tab=core&id=423a86d99c135bcb290b5cdb476ed10e> (last accessed Feb. 1, 2015).

<sup>120</sup> See DEPT. OF HEALTH & HUMAN SERVS., *supra* note 121.

<sup>121</sup> *See id.*

<sup>122</sup> *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> Emily Burke & Erica Schwatz, *Nurse Managed Clinics-Sheridan Health Services a Prime Colorado Model*, 112 COLO. NURSE 1, 5 (2012).

practices for primary care nurse practitioner services threaten the long-term survival of NMHCs. The key uncertainty surrounding NMHCs is whether they can expand beyond academic centers into all areas of the general public.<sup>125</sup> We should reform reimbursement practices for primary care nurse practitioners to preserve access to healthcare for underserved populations and uninsured. Without reimbursement reform nurse-managed health care clinics and other standalone nurse practitioner operated businesses may not survive in the primary health care market. Reimbursement reform is practical starting point that takes into account the financial realities of complete autonomous practice.

#### IV. PLANTING THE MUSTARD SEED: SUGGESTIONS FOR REIMBURSEMENT REFORM

Reimbursement reform for nurse practitioners will require both regulatory and market changes. While advocates continue to work toward regulatory changes, primary care nurse practitioners and nurse academics should consider experimenting with new market-driven payment models.

##### *A. Public and Private Payers Should Credential Nurse Practitioners*

A popular suggestion is for legislators to amend state insurance laws and federal programs to expressly credential nurse practitioners. The Institute of Medicine (“IOM”) suggested Medicare should cover nurse practitioners services just as the program covers physicians now.<sup>126</sup> Medicare should authorize nurse practitioners to perform admission assessments and certify patients for home health care and admission to hospice or skilled nursing facilities.<sup>127</sup> Doing so requires the Centers for Medicare and Medicaid Services to clarify requirements for hospital participation in the Medicare program, such as clinical privileges and membership on medical staff.<sup>128</sup> The IOM also recommended state legislatures require insurers to directly reimburse nurse practitioners if companies participate in fee-for-service payment arrangements with providers.<sup>129</sup> The National

---

<sup>125</sup> Auerback, *supra* note 53 at 1939.

<sup>126</sup> Inst. of Med., *The Future of Nursing: Report Recommendations* (Nov. 11, 2010), <http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health/Recommendations.aspx> (IOM Recommendations hereinafter).

<sup>127</sup> *Id.*

<sup>128</sup> Inst. of Med., *The Future of Nursing: Report Recommendations* (Nov. 11, 2010), <http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health/Recommendations.aspx> (IOM Recommendations hereinafter).

<sup>129</sup> *See id.*

Conference of State Legislatures concurred with the IOM adding that legislators should expressly include nurse practitioners in all primary care initiatives.<sup>130</sup>

State legislatures tried a similar measures in the 1990's. During that time managed care organizations, among other reasons, did not credential nurse practitioners because state law did not require them to do so.<sup>131</sup> Any willing provider ("AWP") and any willing class of provider ("AWCP") laws prohibit health insurance carriers from limiting provider membership based on geography or other characteristics.<sup>132</sup> Twenty-seven states adopted AWP/AWCP laws – seventeen expressly applies to "any provider," ten apply only to pharmacists, physicians, or other providers that are not nurses practitioners.<sup>133</sup> On November 4, 2014 the voters of South Dakota approved Initiative Measure 17, an initiated state statute requiring all insurers list all willing, qualified health care providers that meet conditions for participation.<sup>134</sup>

But the rate of credentialing did not increase despite lawmakers' best intentions. The number of HMO plans that credentialed nurse practitioners in states with AWP/AWCP laws, and states without any form of provider "antidiscrimination" laws hovered around 50% across the board.<sup>135</sup> In hindsight, the statutory text was broad and unspecific leaving little regulatory bite, making enforcement the meaningless.<sup>136</sup> In fact, MCOs regularly challenged the creation of provider antidiscrimination laws. Companies successfully argued that forcing nurse practitioners into their provider networks limited their bargaining power to negotiate lower costs for in-network care increasing "the cost of providing insurance be-

---

<sup>130</sup> Tobler, *supra* note 10.

<sup>131</sup> See Hansen-Turton, *supra* note 33 at 242.

<sup>132</sup> Ashley Nobel, *Health Insurers and Access to Health Care Providers: Any Willing Providers*, NAT'L CONFERENCE OF STATE LEGISLATURES (NOV. 5, 2014), <http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx>.

<sup>133</sup> Ala. Code 1975 § 22-6-158; Ark. Code Ann. §§23-99-201—209; Ark. Code Ann. §§23-99-801—803; 18 Del. Code §7303; Ga. Code Ann., § 33-20-16; Idaho Code Ann. § 41-3927; 215 ILCS 5/370h; Ind. Code 27-8-11-3; Ken. Rev. Stat. Ann. § 304.17A-270 (applies to all providers within the geographic region); Ken. Rev. Stat. Ann. § 304.17C-020 (applies to providers within the geographic area covered by the limited health benefit plan); Ken. Rev. Stat. Ann. § 304.17A-505 (requires carriers to inform enrollees that providers have a right to become members if conditioners are met); La. Rev. Stat. Ann. § 22:2181; Mo. Ann. Stat. § 198.530 (allows residents to receive long-term care at home); Ohio Rev. Code Ann. § 5126.046 (allows people with intellectual disabilities to choose any willing provider for residential services); Tex. Insurance Code Ann. § 1579.108 (applies to general hospitals with limited region); Utah Code Ann. 1953 § 31A-22-617; VA Code Ann. § 38.2-3407; VA Code Ann. § 38.2-4209; Wis. Stat. Ann. § 628.36; Wyo. Stat. Ann. 1977 § 26-34-134; Wyo. Stat. Ann. 1977 § 26-22-503

<sup>134</sup> Health Care Provider Initiated Measure (Aug. 12, 2013) <https://sdsos.gov/elections-voting/assets/PreferredProviderAGTitleAndExplanation.pdf> (last accessed Apr. 12, 2015).

<sup>135</sup> See Hansen-Turton, *supra* note 33 at 242.

<sup>136</sup> See Hansen-Turton, *supra* note 33 at 242.

cause ACP/AWCP laws prevented plans from creating exclusive provider networks.”<sup>137</sup>

However, lawmakers might be more receptive to credentialing laws once the Affordable Care Act is fully implemented. Health care reformers often use Massachusetts as a cautionary tale. In 2006, the Massachusetts legislature enacted a health care reform law that expanded coverage to almost all its residents. But the state had a limited number of primary care doctors and residents experienced a hard time finding primary care providers. Consequently, “emergency department visits ballooned, causing a hump in healthcare costs.”<sup>138</sup> Massachusetts General Hospital had to add fourteen beds to their emergency department to meet the influx of newly insured patients looking for primary care.<sup>139</sup> The legislature resolved the problem by mandating insurers to credential and reimburse NPs for primary care services.

### *B. Federal Qualified Health Centers*

Besides legislative action, primary care nurse practitioner operated businesses could apply for Federal Qualified Health Center (“FQHC”) status. FQHCs are safety net providers “that maintain, expand, and improve the availability and accessibility of essential primary and preventative healthcare services to low-income, medically underserved areas or populations.”<sup>140</sup> FQHC designation allows clinics to increase their revenues without cutting services or adjusting patient volume. The government reimburses clinics at enhanced rates for Medicare and Medicaid visits.<sup>141</sup> Moreover, clinics receive a flat reimbursement rate regardless of the type of visit or primary care provider.<sup>142</sup> The scheme enables the clinic to expand its services to the uninsured, which previously may not have been possible because the clinic could not afford to provide uncompensated care.<sup>143</sup>

Aside from regulatory compliance, nursing administrators considering FQHC should carefully weigh whether to form a partnership with another FQHC entity. Billing decisions could either improve or further decrease revenue for the clinic. Assuming the clinic chooses to bill

---

<sup>137</sup> See Hansen-Turton, *supra* note 33 at 244 (citing Kentucky Association of Health Plans v. Miller, 538 U.S. 329 (2003)).

<sup>138</sup> Stokowski, *supra* note 104.

<sup>139</sup> See Stokowski, *supra* note 104.

<sup>140</sup> Marlene Sefton, Emily Brigell, Charlie Yingling & Judy Storfjell, *A journey to become a federally qualified health center*, 23 J. AM. ACAD. NURSE PRAC. 346, 347 (2011).

<sup>141</sup> *Id.*

<sup>142</sup> *Id.* at 350.

<sup>143</sup> Marlene Sefton, Emily Brigell, Charlie Yingling & Judy Storfjell *supra*, at 350.

through its partner, administrators should be prepared to negotiate for the clinic's economic and management interests. In one example, a clinic eventually partnered with another FHQC center that agreed to transfer patient revenue back to the clinic in exchange for a small processing fee.<sup>144</sup> Other entities offered to compensate the clinic a modest percentage and demanded greater ownership and control of the clinic.<sup>145</sup>

### C. Provider Payment Reform Models

Reimbursement reform for nurse practitioners coincides with the health care industry's general desire to reform provider payment. Principles that guide provider payment reform include efficiency, effectiveness, quality of health care delivery systems, and holistic management for complex medical problems.<sup>146</sup>

New payment initiatives benefit nurse practitioners for two reasons. First, new models recognize the monetary value of the services provided by nurses and nurse practitioners. For decades nurses have "been 'revenue invisible,' meaning that nursing services are not separated from the institutional room fee or other professional fees on the billing statements . . . ."<sup>147</sup> Dr. David Asch, former chief of general medicine at Pennsylvania VA Medical Center, believes nursing experience is relevant to modified reimbursement practices. "The value of education attenuates very rapidly. I will take a very experienced nurse practitioner over an inexperienced physician any day because so much of what people learn that will be of particular use comes after they completed their degree program."<sup>148</sup>

Second, new payment models align financial incentives of the nurse practitioners with the interests of patients and payers to receive (or pay) for quality care.<sup>149</sup> Two promising models for primary care nurse

<sup>144</sup> *Id.* at 348.

<sup>145</sup> *Id.*

<sup>146</sup> Nat'l Comm'n of Physician Payment Reform, *Report of the National Commission on Physician Payment Reform* 13 (Mar. 2013), [http://physicianpaymentcommission.org/wp-content/uploads/2013/03/physician\\_payment\\_report.pdf](http://physicianpaymentcommission.org/wp-content/uploads/2013/03/physician_payment_report.pdf)

<sup>147</sup> Debra Hain & Laureen M. Fleck, *Barriers to Nursing Practice that Impact Healthcare Redesign*, ONLINE J. ISSUES NURSING (May 31, 2014), <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-19-2014/No2-May-2014/Barriers-to-NP-Practice.html>.

<sup>148</sup> The Wharton School of the Univ. of Pennsylvania, *Nurse Practitioners Are In – and Why You May Be Seeing More of Them*, KNOWLEDGE @ WHARTON (Feb. 13, 2013), <http://knowledge.wharton.upenn.edu/article/nurse-practitioners-are-in-and-why-you-may-be-seeing-more-of-them/>.

<sup>149</sup> Bailit Health Purchasing, LLC, *Payment Matters: ROI for Payment Reform*, ROBERT WOOD JOHNSON FOUND. 1 (Feb. 2013), [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2013/rwjf404563](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404563) [hereinafter Robert Wood Johnson Found.].

practitioners led clinics illustrate this idea. Population-based payment involves a provider entity taking full responsibility for a group of patients in exchange for a set amount of money.<sup>150</sup> “Reimbursement is contingent on nurse practitioners efficiently managing care and performing well on quality-of-care targets.”<sup>151</sup> Similarly, patient-centered medical home payment accepts responsibility for keeping a patient healthy.<sup>152</sup> Care plans are optimized to meet the patient’s individual dietary, physical, behavioral, pharmacological needs. Providers receive a certain amount of money per patient per month from insurance companies and other payers to provide enhanced outreach, communication, and coordination so long as providers meet certain performance criteria.<sup>153</sup>

Payment reform is still in its infancy, which does not immediately help NMHCs or similar clinics struggling to stay open. Moreover, market-driven payment models require disclosure of practitioner performance information to facilitate consumer decision making. However, the Agency for Healthcare Research and Quality’s Report Card Compendium lacks quality reports on nurse practitioners who practice independently or in a collaborative practice.<sup>154</sup> Until federal and state agencies catch up, nursing organizations and academic institutions should take the lead in releasing nurse practitioner performance data. Providing the resources necessary to support market-driven models could help primary care nurse practitioner business shift to new payment models.

## VI. CONCLUSION

Health care reform is a challenge that requires more primary care providers. The industry has known for a while that nurse practitioners improve access to primary health care services because they deliver high quality care at affordable prices. Even in the face of such adversity the seeds of a practical beginning should be sown today. The goal of complete professional autonomy for primary care nurse practitioners is provide the financial option for independently practice whether that be in a nurse-managed health clinic or privately owned offices. Reimbursement reform encourages entrepreneurial nurse practitioners to enter the primary health

---

<sup>150</sup> *Id.*

<sup>151</sup> *Id.*

<sup>152</sup> *Id.* at 2.

<sup>153</sup> *Id.*

<sup>154</sup> Mary D. Naylor & Ellen T. Kurtzman, *The Role of Nurse Practitioners in Reinventing Primary Care*, 29 HEALTH AFF. 897 (2010).

care market. More importantly, reimbursement reform safeguards those businesses so that they might have time to germinate and grow.