

Health-Care Reform: Opportunities for APRNs and Urgency for Modernizing Nurse Practice Acts

Eileen T. O'Grady, PhD, RN, ANP-BC, and Andrea Brassard, DNSc, MPH, FNP

The Health Care and Education Reconciliation Act of 2010, for the most part, represents solutions to our health-care delivery system and insurance market inequities. The legislation directly addresses the thorny nature of our blended public-private health-care enterprise and builds on the uniquely American employer-sponsored health insurance system. The act addresses many problem-laden characteristics of the delivery system, including the lack of access to coverage, health-care workforce planning, and alignment of payment with outcomes, financing, quality, and safety. The opportunities for advanced practice registered nurses (APRNs) in this legislation are colossal. As the Act unfolds over the coming years, key provisions undergird the need for highly qualified APRNs. In this article, these provisions are viewed through the lens of nurse practice acts that do not conform to national standards in the APRN Consensus Report. Then, specific recommendations from stakeholders regarding the urgency to reform, standardize, and modernize the nation's scope-of-practice regulations for APRNs are reviewed.

The Health Care and Education Reconciliation Act of 2010, also known as Patient Protection and Affordable Care Act of 2010 (ACA), addresses the problems of our health-care system and health insurance system. Many of the solutions in the legislation provide opportunities for advanced practice registered nurses (APRNs) in primary care (see Table 1) and thus create an urgent need to broaden their scope of practice.

Effects of Health Reform Legislation on APRNs

The ACA has several provisions that affect APRNs directly or expand access to care, thereby increasing demand for health services in every sector of care delivery. The patient protections that will likely increase the demand for APRNs include prohibiting insurers from refusing coverage because of preexisting conditions, eliminating lifetime limits, expanding dependent coverage until age 26, mandating that everyone have health insurance or pay a fee, prohibiting insurers from cost-sharing preventive services, and offering a free annual physical exam to all Medicare beneficiaries.

The ACA also increases the federal investment in nursing workforce development by nearly 50%. Additional funding is directed at nursing student loans, nurse-faculty loans to address the 800 nursing faculty vacancies in 2009, investments in nursing bridge and accelerated programs, geriatric and pediatric nursing programs, and nursing diversity programs.

The legislation has a number of provisions that present astonishing opportunities for APRNs. It is replete with provider-

neutral language and acknowledges that APRNs are ideal primary, prevention, and transitional-care providers. The opportunities include a \$150 million study across five hospitals to establish the effectiveness of graduate nurse education, demonstration grants for family nurse practitioners (FNPs) to receive a 1-year immersion (residency) program with full-time pay, Medicare payment to certified nurse-midwives (CNMs) at 100% of the physician rate, new funding for nurse-managed health clinics, and a \$4 billion boost to the National Health Service Corps.

Primary-Care Provisions

When the mandated insurance provision and federal subsidies for low-income people take effect in 2014, about 32 million Americans will become insured. This influx of newly insured people is expected to substantially increase demand for health care, especially primary care. The ACA defines *primary care* as the provision of integrated, accessible health-care services by clinicians who are accountable for addressing a large majority of personal health-care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The ACA includes nurse practitioners (NPs) and clinical nurse specialists as primary-care practitioners eligible for incentive payments for primary-care services. CNMs are also recognized as primary-care providers. In addition to care before, during, and after childbirth, CNMs provide primary-care services to women from adolescence to late life. Effective January 1, 2011, the ACA ensures 100% reimbursement for Medicare Part B services provided by CNMs—a significant increase over the 65% reimbursement rate in place for decades. Because many

TABLE 1

APRNs in Primary Care

Primary-care advanced practice registered nurses (APRNs) include nurse practitioners (NPs), who work in community-based settings, and certified nurse-midwives, who provide community-based women's health care. No reliable national data break down the number of NPs practicing by sector, such as acute care, end-of-life care, and primary care. A survey of NPs in New York state ($n = 8,208$) found, however, that nearly half of the state's NPs worked in the primary-care sector (Center for Health Workforce Studies, 2004). Of graduating NPs, 84% enter the primary-care workforce, but estimating the APRN primary-care workforce is difficult because of overlapping specialties, blended NP and clinical nurse specialist (CNS) practice roles, and various titling by states (Anderson & O'Grady, 2008). While the number of NPs continues to grow and the doctor of nursing practice programs expand, predicting whether the growth will be faster in primary or specialty settings is difficult.

The summary of research on the role of APRNs suggests that the safety and quality of APRN-delivered care across settings is at least equivalent to the safety and quality of physician-delivered care. No studies comparing CNSs with physicians have been conducted, but CNSs appear to demonstrate competence and cost-savings as case managers for patients transitioning from acute care to home care (O'Grady, 2008).

Medicaid programs and private insurers follow Medicare reimbursement rates, this provision could trigger a ripple effect of improved reimbursement for midwifery services.

The ACA establishes primary-care extension programs administered through the Agency for Healthcare Quality and Research to educate providers about prevention, health promotion, chronic disease management, mental and behavioral health, and evidence-based practice. Similar to the Cooperative Agricultural Extension Services, such programs will enhance the primary-care infrastructure in rural areas, using consultation and expert assistance in developing efficient primary-care operations, such as electronic health records (EHRs) and collaborative practice. The primary-care extension program will award grants to states, so they can establish hubs that coordinate health-care functions with quality improvement organizations and area health education centers. APRN associations and practice-based research networks could join with these hubs to promote collaboration (Grumbach & Mold, 2009). However, in states that have restrictive regulations and do not recognize APRNs as primary-care providers, APRNs may not be counted in primary-care extension programs.

Nursing Workforce Provisions

The ACA includes a provision that directs 10% of the National Health Service Corps funding toward loan repayment programs for FNPs and CNMs serving in health-professional shortage

areas for 2 years. The legislation also defines the term *nurse-managed health clinic* and provides funding for developing and operating APRN-led clinics. In 2009, nurse-managed health clinics recorded more than 2.5 million patient visits and provided primary-care services to more than a quarter of a million patients nationwide (Ritter, 2009). These clinics not only deliver primary care to thousands of the underserved but also provide clinical sites for educating nurses and other health-care professionals.

Primary-care delivery in these clinics is constrained by state laws that require physician supervision or collaboration because insurers in these states are much less likely to credential APRNs as primary-care providers (Ritter, 2009). [For more information on nursing workforce provisions, see Table 1, which appeared in the July 2010 issue of the *Journal of Nursing Regulation* \(Cleary, 2010\). CS: change green to read as below for clarity \(to avoid confusion with the Table 1 in this piece and since there is more than one "Table 1" in the July issue\). As meant?](#)

For more information on nursing workforce provisions, see "Health Care Reform Law: Nursing Workforce Provisions" (Table 1, page 29, in the July 2010 issue of the *Journal of Nursing Regulation*; Cleary, 2010).

Home-Visitation Programs

APRNs can also provide primary care through maternal, infant, and early childhood home-visitation programs. The home-visitation program will be administered by the Health Resources and Services Administration's Maternal and Child Health Bureau in collaboration with the Administration for Children and Families. The ACA authorizes grants of \$1.5 billion over 5 years to states, tribes, and other eligible entities to provide voluntary home-visitation services to eligible families and promote positive outcomes for children and families. Pediatric NPs, FNPs, and CNMs are well suited to lead these programs. In states with restrictive scope-of-practice laws and regulations, care will be delayed, and costs will be higher because these APRNs must contact their collaborating or supervising physicians for approval of their care plans.

Exchanges

The ACA makes broad changes in the way health insurance will be provided by creating exchanges, which are state-based marketplaces for purchasing insurance coverage. In the coming months, states will choose whether to operate their own exchanges or participate in regional (multistate) or national exchanges. These exchanges are the key element in providing coverage to those currently uninsured and in facilitating changes to the insurance market by creating sizable and stable risk pools and more consumer choice. The exchanges are intended to protect patients and to create a more organized and competitive market for health insurance by offering a choice of health plans, establishing common rules, and making offerings and pricing transparent. Overall, the goal is to have a central place that provides information to help

consumers better understand their options. Initially, exchanges will primarily serve people purchasing insurance on their own and small-business employers. The expectation is that over time, exchanges will lead to an unlinking of insurance and employment and make insurance portable (Kaiser Family Foundation, 2009). Regional (multistate) exchanges will present a major issue for APRNs because of the different scope-of-practice laws. This circumstance could cause great confusion and may accelerate the modernizing of scope-of-practice laws in states with regional exchanges.

Testing New Financing and Delivery Models

The ACA commits \$10 billion over 10 years for the new Center for Medicare & Medicaid Services (CMS) Innovation Center to create national experiments to quickly test new ways to provide and pay for high-value care. The goal of the Innovation Center is to explore new approaches, so we have better results in terms of the quality of care and the affordability of coverage. The Innovation Center shows great promise in creating new “journeys of care” to make threshold improvements in safety and quality by identifying and scaling models of care that improve outcomes. Four priority strategies—accountable care organizations, medical homes, primary care in the home, and transition care—are highly relevant to APRNs.

Accountable Care Organizations

Beginning in January 2012, accountable care organizations (ACOs) will manage and coordinate care across all settings for fee-for-service Medicare beneficiaries. Early research on bundled payment is showing great promise in terms of how delivery systems can more efficiently provide care. The Innovation Center will expand testing of bundled payments in which a single payment is made for all services related to a treatment or condition, potentially spanning multiple providers in multiple settings. Providers assume the financial risk for the cost of services associated with a condition or treatment and the cost associated with preventable complications. Providers do not assume financial risk for the occurrence of the medical conditions. Bundled payment supports coordination of care by sharing payment across providers in multiple settings. ACOs that achieve benchmarks for quality and cost-savings share the savings. Payment models and ACO structure are flexible, but each ACO must have at least 5,000 beneficiaries and must demonstrate that it meets patient-centered criteria and quality performance standards.

This payment strategy is expected to increase the use of APRNs in many roles and the ability of APRNs to practice across institutional and community settings. However, APRNs must be qualified as ACO professionals without physician direction or supervision. Moreover, APRNs must be included in the profit incentive, so they are best positioned to direct and shape

care delivery as highly qualified experts in health care, health promotion, and disease management.

Medical Homes

The *patient-centered medical home*, another top priority for the CMS, is defined as a health-care setting that facilitates partnerships between individual patients and their personal physicians—and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange, and other means to ensure that patients receive the indicated care when and where they need and want it in a culturally and linguistically appropriate manner (National Committee for Quality Assurance [NCQA], 2010).

The patient-centered medical home is one way to reengineer care management for those with chronic diseases. Evidence shows that medical homes dramatically decrease hospitalization rates and emergency department use and improve quality outcomes (Grumbach & Grundy, 2010). Medical-home delivery of care emphasizes the patient and family and includes education, enhanced access to acute and chronic disease care, an expanded scope of services, team-based care, and the optimization of chronic disease management and preventive care through planned visits enabled by EHRs (Steele et al., 2010). All patient-centered medical homes are to include expanded access and communication, test and referral tracking, disease registries, care management, patient self-management support, electronic prescribing, performance reporting and improvement, and advanced electronic communications (NCQA, 2010).

Primary Care in the Home

Another home-visitation program authorized by the ACA is the Independence at Home Medical Practice Demonstration Program. This program creates an incentive payment and delivery model that uses NPs and physicians to direct home-based primary-care teams to reduce cost and improve health outcomes. This section of the ACA states that nothing shall prevent an NP from participating in or leading a home-based primary-care team. As practice sites for demonstration programs are selected, restrictive APRN scope-of-practice laws and regulations will be barriers to implementation. Medicare currently allows only physicians to certify patients for home health care, creating an enormous barrier to APRN-led home-based primary care nationwide.

Transition Care

Transitioning from health-care facilities to home is another focus of the ACA. Medicare claim data show that more than one-third of beneficiaries discharged from the hospital are re-hospitalized in 90 days, which is a great expense to Medicare and a risk to patients’ health (Jencks, Williams, & Coleman, 2009). The community-based care-transitions program provides funding to eligible hospitals and community-based organizations to improve care-transition services to high-risk Medicare beneficiaries. Such

programs seek to prevent hospital readmissions for patients with chronic conditions. This ACA provision is widely acknowledged as an expansion of the work of Mary Naylor, PhD, RN, FAAN, whose transitional-care model emphasizes the role of APRNs. The ACA provision does not specify the use of a particular model of transitional care, nor does it require the use of any particular type of provider (Keepnews, 2010). APRNs are well suited to provide this type of care because of their expertise in managing people within the context of their families and communities. However, until APRNs are permitted to certify homebound patients for Medicare home health services, transitional-care programs will encounter delays and higher costs.

APRN Regulatory Environment Thwarts Innovation

As practices expand services in these new directions and 32 million Americans are swept into the delivery system, the demand for APRN services will likely surge. However, restrictions in nearly half of the nation's nurse practice acts will stifle innovation in new care-delivery models. Numerous restrictions that are not evidence-based prevent APRNs from practicing at the top of their licenses. For example, APRNs in some states are restricted from utilizing their full skill set, such as treating chronic pain, certifying for workers' compensation, conducting sports physicals, referring patients for physical therapy, and ordering durable medical equipment (Safriet, 2010). Unless and until the unnecessary regulatory restrictions on APRN practice are lifted across the United States, distortions in efficient practice will thwart the spirit and effectiveness of bundled payments, patient-centered medical homes, care transitions, and other innovative care-delivery models.

Voices Grow Louder

A number of organizations outside the APRN community have recently reported on and made recommendations regarding the variations and restrictions across our nation's nurse practice acts. These restrictions present a major block to improving the health of Americans, the underlying intent of the ACA.

Citizen Advocacy Center

The Citizen Advocacy Center (CAC) serves the public interest by enhancing the effectiveness and accountability of health-profession oversight bodies. Originally created to boost the effectiveness of citizens serving as consumer representatives on oversight bodies, the CAC soon became a resource for the health professional boards themselves. In 2010, it published *Reforming Scopes of Practice: A White Paper* (LeBuhn & Swankin, 2010), which strongly recommends that we dramatically change the way we approach scope-of-practice disputes based on these assumptions:

- The purpose of regulation, public protection, should have top priority in scope-of-practice decisions, rather than professional self-interest.
- Changes in scope of practice are inherent in our health-care system.
- Collaboration among the health professions should become the professional norm.
- Overlap among the professions is necessary.
- Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service.

National Health Policy Forum

The National Health Policy Forum created a background paper, *Tapping the Potential of the Health Care Workforce: Scope-of-Practice and Payment Policies for Advanced Practice Nurses and Physician Assistants* (Cunningham, 2010). The paper assumes that health-care reform will force the APRN and physician assistant (PA) professions to continue to grow rapidly, while demand surges. The paper states the following:

- The highly variable and inconsistent scope-of-practice laws across the nation will complicate the education, credentialing, and employment of APRNs and PAs.
- Scope-of-practice inconsistencies will thwart delivery-system innovation and promising team-based care models and waste investments in education when APRNs are not allowed to fully practice.
- The pace of the expansion of scope-of-practice laws, especially those on prescriptive authority, is glacial, and the sketchy written protocols are illogical and wasteful.
- The American Medical Association's opposition to autonomous practice for APRNs is unfounded and contradicts published research.
- The demand for APRNs will swell in the coming years, and the capacity for our nation to redress access concerns will depend on the resolution of tensions about scope of practice.

The paper recommends either a model state nurse practice act or a process for evaluating scope-of-practice legislation.

Institute of Medicine

The Robert Wood Johnson Foundation and the Institute of Medicine (IOM) launched a 2-year initiative to reconceptualize and transform the nursing profession. The IOM appointed the Committee on the Initiative on the Future of Nursing, which produced an evidence-based report that recommends an action-oriented blueprint for the future of nursing. The report explores how nurses' roles, responsibilities, and education should change significantly to meet the increased demand for care that will be created by health-care reform and to advance improvements in America's increasingly complex health system (Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, 2010).

This report offers recommendations for a variety of stakeholders—including state legislators, the CMS, and the U.S. Congress—to ensure that nurses can practice to the full extent of their education and training. The federal government is particularly well suited to promote the reform of scope-of-practice laws by providing incentives for the adoption of best practices. One sub-recommendation urges the Federal Trade Commission, which has long targeted anticompetitive conduct in the health-care market, to review state regulations concerning APRNs to identify those that have anticompetitive effects without contributing to the health and safety of the public.

Eight bold recommendations strengthen and improve APRN practice and make nursing more central to care delivery. Under Recommendation 1, two of the nine sub-recommendations—one for the Congress and one for state legislatures—are worthy of attention:

Recommendation 1: Remove scope-of-practice barriers. Advanced practice registered nurses should be able to practice to the full extent of their education and training. To achieve this goal, the committee recommends the following actions:

- Limit federal funding for nursing education programs to only those programs in states that have adopted the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules (Article XVIII, Chapter 18).
- Reform scope-of-practice regulations to conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules (Article XVIII, Chapter 18).

If the current scope-of-practice expansion process is not reformed, modernizing and standardizing the state practice acts to comply with professional standards in the APRN Consensus framework may take decades. Incentives to accelerate the pace of modernization include the federal government giving favorable funding preferences only to states that have modernized their nurse practice acts.

Action Steps for APRNs, Advocacy Groups, and Regulators

The ACA recognizes and amplifies the role of APRNs by way of expanding access to primary care and other health services, but the recognition of NPs and other APRNs as primary-care providers varies widely among the states (Pearson, 2010). APRNs, APRN organizations, and advocacy groups must accelerate the modernization of the practice acts that do not comply with the APRN Consensus Report. The National Council of State Boards of Nursing has many resources that can help boards of nursing and legislators adopt the requirements of the Consensus

Model for APRN Regulation (National Council of State Boards of Nursing, 2010).

How the newly defined patient-centered homes and ACOs will ensure APRNs are included is uncertain. APRNs must be vigilant about monitoring the medical-home and ACO activities in their states and ensuring that APRNs are positioned for leadership in these emerging systems.

Encouraging the federal government to grant favorable funding status to states with modernized nurse practice acts will expand the range and number of stakeholders far beyond the nursing community. This strategy will undoubtedly create many problems for states with outdated practice acts, but it will accelerate the pace of change and force policy makers to align their nurse practice acts with national professional standards.

APRNs must be competitors in the health-exchange marketplace. APRNs must not accept or be limited to roles solely as employees for physician groups or hospitals: They must be providers with patients who have direct, transparent access. Maintaining this position will require unwavering vigilance and fierce APRN leadership in the planning and development of regional and state exchanges.

APRNs have a critically important role to play in shaping and influencing the transformation of health care into a system that provides accessible, humane, and essential health services while improving quality and controlling costs. Undoubtedly, health reform cannot be accomplished without strong leadership, maximal contributions from APRNs, and the removal of unnecessary barriers to APRN practice.

References

- AARP Public Policy Institute. (2010). Nursing provisions P.L. 111–148, the Patient Protection and Affordability Care Act. Retrieved from <http://championnursing.org/sites/default/files/nursingand-healthreformlawable.pdf> CS: this ref is not cited in text. [Delete here?](#)
- Anderson, A., & O'Grady, E. T. (2008). The primary care nurse practitioner. In A. B. Hamric, J. A. Spross, & C. M. Hanson (Eds.), *Advanced practice nursing: An integrative approach* (4th ed.). St. Louis, MO: Elsevier-Saunders.
- Center for Health Workforce Studies. (2004). Nurse practitioners in New York state: A profile of the profession in 2000. Retrieved from <http://chws.albany.edu/index.php?center-e-newsletter-april-2006>
- Cleary, B. (2010). Building a nursing workforce for the 21st century. *Journal of Nursing Regulation*, 1(2), 26–30.
- Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. (2010). The future of nursing: Leading change, advancing health. Retrieved from http://www.rwjf.org/files/research/Future%20of%20Nursing_Leading%20Change%20Advancing%20Health.pdf
- Cunningham, R. (2010). Tapping the potential of the health care workforce: Scope-of-practice and payment policies for advanced practice nurses and physicians assistants. National Health Policy Forum. Retrieved from <http://www.nhpf.org/library/details.cfm/2808>

- Grumbach, K., & Grundy, P. (2010). Outcomes of implementing patient-centered medical home interventions: A review of the evidence from prospective evaluation studies in the United States. Retrieved from http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf
- Grumbach, K., & Mold, J. (2009). A health care cooperative extension service. *Journal of the American Medical Association*, 301(24), 2589–2591.
- Jencks, S. F., Williams, M. V., & Coleman, E. A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine*, 360(14), 1418–1428. Retrieved from <http://performanceclinical.com/news/files/nejmsa0803563.pdf>
- Kaiser Family Foundation. (2009). Focus on health reform: What are exchanges? Retrieved from <http://www.kff.org/healthreform/upload/7908.pdf>
- Keepnews, D. (2010). Implementing health care reform: Issues for nursing. American Academy of Nursing. Retrieved from <http://www.aannet.org/files/public/ImplementingHealthCareReform.pdf>
- LeBuhn, R., & Swankin, D. (2010). Reforming scopes of practice: A white paper. Citizens Advocacy Center. Retrieved from <http://www.cacenter.org/files/ReformingScopesofPractice-WhitePaper.pdf>
- National Council of State Boards of Nursing. (2010). APRN consensus model: A new framework for the regulation of advanced practice registered nurses (APRNs). Retrieved from <https://www.ncsbn.org/170.htm>
- National Committee for Quality Assurance. (2010). Recognizing physician practices as medical homes fact sheet. Retrieved from <http://www.ncqa.org/tabid/631/default.aspx>
- O'Grady, E. T. (2008). Advanced practice registered nurses: The impact on patient safety and quality. In R. G. Hughes (Ed.), *Patient safety and quality: An evidence-based handbook for nurses*. Rockville, MD: Agency for Healthcare Research and Quality.
- Pearson, L. (2010). The Pearson Report: A national overview of nurse practitioner legislation and healthcare issues. *American Journal for Nurse Practitioners*, 14(2), 49–51.
- Ritter, A. (2009). Insurers' policies on nurse practitioners as primary care providers: Two years later. *NNCC Update*. Retrieved from <http://www.nncc.us/docs/NNCC09Newsletter.pdf>
- Safriet, B. (2010). Federal options for maximizing the value of advanced practice nurses in providing quality, cost effective health care. In Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. *The future of nursing: Leading change, advancing health* (Appendix 11). National Academies Press, Washington, DC.
- Steele, G. D., Haynes, J. A., Davis, D. E., Tomcavage, J., Stewart, W. F., Graf, T. R., et al. (2010). How Geisinger's advanced medical home model argues the case for rapid-cycle innovation. *Health Affairs*, 29, 2047–2053.

Eileen T. O'Grady, PhD, RN, ANP-BC, is a visiting professor at Pace University, New York, New York, and a policy editor and columnist for *Nurse Practitioner World News* and the *American Journal for Nurse Practitioners*. **Andrea Brassard, DNSc, MPH, FNP**, is a strategic policy advisor at the Center to Champion Nursing in America at AARP, Washington, DC.