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

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Abstract

In 2014, the Affordable Care Act will create an estimated 16 million newly insured people. Coupled with an estimated shortage of over 60,000 primary care physicians, the country’s public health care system will be at a challenging crossroad, as there will be more patients waiting to see fewer doctors. Nurse practitioners (NPs) can help to ease this crisis. NPs are health care professionals with the capability to provide important and critical access to primary care, particularly for vulnerable populations. However, despite convincing data about the quality of care provided by NPs, many managed care organizations (MCOs) across the country do not credential NPs as primary care providers, limiting the ability of NPs to be reimbursed by private insurers. To assess current credentialing practices of health plans across the United States, a brief telephone survey was administered to 258 of the largest health maintenance organizations (HMOs) in the United States, operated by 98 different MCOs. Results indicated that 74% of these HMOs currently credential NPs as primary care providers. Although this represents progress over prior assessments, findings suggest that just over one fourth of major HMOs still do not recognize NPs as primary care providers. Given the documented shortage of primary care physicians in low-income communities in the United States, these credentialing policies continue to diminish the ability of NPs to deliver primary care to vulnerable populations. Furthermore, these policies could negatively impact access to care for thousands of newly insured Americans who will be seeking a primary care provider in 2014. (Population Health Management 2013;16:xxx–xxx)

Introduction

Approximately 56 million Americans—nearly 1 in 5—lack adequate access to primary health care because of physician shortages in their communities. This situation is predicted to worsen. According to the Association of American Medical Colleges, there will be a shortfall of 29,800 primary care physicians by the year 2015, and 65,800 by the year 2025. This shortfall will occur largely because of the anticipated increase in demand for services resulting from the Affordable Care Act, but also because of the general growth of the American population, particularly the elderly population, and the declining proportion of medical students who are choosing a primary care career in favor of more lucrative specialized fields of medicine. Although the shortage of primary care physicians will have harmful effects on all communities and every individual, it will be felt most acutely in medically disenfranchised communities, where physicians are already caring for fewer Medicaid and uninsured patients than in years past.

Nurse practitioners (NPs), advanced practice nurses (APNs) with specialized qualifications, are able to perform many of the same services delivered by primary care physicians. NPs provide wellness and preventive care services; diagnose and manage common, uncomplicated acute illnesses; order tests and referrals; help patients manage chronic diseases; and write prescriptions. NPs constitute one of 4 APN roles, and represent the largest number of APN graduates each year (approximately 7000), with a majority of those graduates (almost 6000) having a primary care focus.
Every year, throughout the United States, hundreds of thousands of vulnerable and medically underserved individuals receive care from an NP. NPs provide cost-effective care that is comparable in quality to the care delivered by primary care physicians. In the landmark 2010 report "The Future of Nursing," the Institute of Medicine concluded, after an exhaustive review of all available studies of the efficacy and safety of care provided by advanced practice registered nurses, that APNs can independently provide core care services as effectively as physicians.

Despite evidence showing that NPs deliver high-quality, cost-effective primary care to many of the country’s most vulnerable citizens, NPs in primary care still struggle for parity with recognition and reimbursement from third-party payers. Many managed care organizations (MCOs) have historically refused to credential NPs as primary care providers. Hansen-Turton and colleagues reported MCO credentialing rates of 33% in 2005 and 53% in 2007. Moreover, among those MCOs that do credential NPs as primary care providers, many continue to reimburse NPs at a lower rate than primary care physicians for the delivery of this care. These prohibitive policies not only diminish the capacity of NPs and the health care centers in which they work to provide care to patients, but they also threaten the long-term sustainability of these critical health care providers.

Although these practices may negatively impact access to care for any participant in a managed care plan, they are especially likely to impact access to care for Medicaid managed care beneficiaries. According to the Kaiser Commission on Medicaid and the Uninsured, 70% of Medicaid enrollees receive some or all of their services through a managed care plan. Thus, when MCOs refuse to credential NPs as primary care providers or to reimburse for care at the rate of primary care physicians, Medicaid populations likely will be affected the most by these restrictive practices.

This is a report on the results of a recent assessment of the credentialing and reimbursement practices of the largest MCOs in the United States. The authors assess the practices of these MCOs in credentialing NPs as primary care providers, and also assess whether these MCOs reimburse NPs at the same rate as primary care physicians. In additional analysis, differences in the credentialing and reimbursement practices of MCOs with large Medicaid, Medicare, and commercial health maintenance organization (HMO) product lines are examined.

Methods

In 2011–2012, the National Nursing Centers Consortium conducted a survey of 258 HMOs operated by 98 MCOs. As used in this article, an MCO is defined as, “any parent company, ownership group, or affiliate operating an HMO or PPO [preferred provider organization] line of business, or any stand-alone organization (not part of a larger group or company) operating an HMO or PPO line of business.” An HMO is defined as, “a health plan that offers prepaid, comprehensive health coverage for both hospital and physician services; members are usually required to access services from an approved list of participating providers.” MCOs offer multiple insurance plans. An insurance plan may or may not contain HMO beneficiaries. HMOs were chosen because so many Medicaid beneficiaries are enrolled in an HMO, and because research provides evidence that NPs are more likely than primary care physicians to practice in underserved areas and to care for Medicaid beneficiaries.

Using purposive sampling, researchers compiled a target contact list of the 10 largest MCOs in each of the 50 states and the District of Columbia. The 10 largest plans were determined based on the numbers of HMO enrollees reported in the HealthLeaders-InterStudy Competitive Edge Managed Care Directory. The largest MCOs were selected in order to capture plans with higher impact and influence on the state’s health insurance market, resulting from enrollee volume. In the case of MCOs with operations in multiple states, interviewers counted each MCO’s HMO operating in the state as a separate plan, despite the fact that many large MCOs adopt uniform company-wide credentialing policies across their HMOs. In addition, an MCO may have more than 1 HMO that falls into the top 10 insurance plans by HMO enrollment in some states. This method of tabulation was selected to determine the true impact of managed care consolidation on providers in different states throughout the country. In some instances, states did not have 10 HMO plans, in which case all HMO plans listed in the HealthLeaders-InterStudy Directory for that state were included. A total contact list of 499 HMOs was compiled from the Directory. Interviewers contacted each of the 499 HMO plans to determine current NP credentialing and reimbursement practices. In most instances, the interviewee spoke with a representative from the credentialing or provider relations department of the HMO. Of the 499 HMOs contacted, brief interviews were completed with representatives from 258 HMOs, yielding a response rate of 52%. This is similar to previous reports in the literature on the credentialing practices of MCOs. Nonrespondents included 134 HMO representatives who declined to participate, and 103 HMOs where, after repeated contacts, the authors were unable to reach a representative who could describe credentialing and reimbursement practices.

A brief telephone survey was administered to the 258 participating HMOs. Survey questions focused on credentialing and reimbursement policies of the HMOs. This article reports on responses to 2 primary questions of interest. HMO representatives were asked whether they currently credential NPs as primary care providers. Those responding “yes” were subsequently asked whether the HMO reimburses NPs at the same rate as primary care physicians.

Results

Of the 258 HMOs surveyed, 192 (74%) reported that they credential NPs as primary care providers, while 66 (26%) do not. Two HMOs reported that they do not normally credential NPs as primary care providers except under specific circumstances such as a primary care physician shortage in a rural area. For purposes of this analysis, these 2 HMOs were grouped with noncredentialing HMOs.

Data were obtained on reimbursement practices from 144 of the 192 HMO plans that credential NPs as primary care providers. Of these 144 HMOs, 39 (27%) reported that they reimburse NPs at the same rate as primary care physicians,
39 (27%) reported reimbursing at a lower rate, and 66 (46%) reported that their reimbursement rates varied and that sometimes NPs were reimbursed at the rate of primary care physicians.

To further assess the credentialing practices of these HMOs, the authors examined practices among HMOs with significant numbers of enrollees in Medicaid, Medicare, or commercial managed care plans. This analysis included only those HMOs in which 30% or more of total HMO enrollees were enrolled in a Medicaid, Medicare, and/or commercial product line (as reported in the HealthLeaders-InterStudy Directory 2011). Of the 258 HMOs surveyed, 119 HMOs had ≥30% of enrollees enrolled in a Medicaid managed product line, 89 HMOs had ≥30% enrollees enrolled in a Medicare product line, and 111 HMOs had ≥30% of enrollees enrolled in a commercial product line. Figure 1 shows the percentage of MCOs that credential NPs as primary care providers, broken down by HMO product line. Of the HMOs with significant numbers of enrollees in a Medicaid, Medicare, or commercial managed care product line that reported credentialing NPs as primary care providers, those serving Medicaid managed care enrollees were the most likely to report that they reimburse NPs at the same rate as a primary care physician. Figure 2 shows the percentage of MCOs that reimburse NPs at the same rate as primary care providers, broken down by HMO product line.

Discussion

With impending health reform providing new access to primary care for millions of Americans, there has never been a more urgent time to strengthen primary care.14 With dwindling numbers of medical students choosing primary care careers, NPs are poised to help close the primary care gap, yet credentialing and reimbursement policies of the nation’s largest MCOs continue to diminish the effective and efficient use of NP services. Findings from this study indicate that among MCOs in the United States operating the largest HMO product lines, 74% currently credential NPs as primary care providers. Relative to prior reports in the literature, this signals an improvement. In 2005 and 2007 surveys of MCOs, 33% and 53% reported credentialing NPs as primary care providers, respectively.9,10 Although this progress is encouraging, results indicate that among the major managed care plans in the United States, 1 in 4 still does not credential NPs as primary care providers. Moreover, there has been little change in the credentialing practices of NPs by Medicaid managed care companies in recent years. In a 2007 survey of managed care credentialing policies of MCOs with significant Medicaid HMO product lines, 74% reported that they credential NPs as primary care providers.9 Five years later in 2012, this figure has increased only slightly (76%).

With the current supply of primary care physicians already being outpaced by rising demand, there has never been a more pressing nor more opportune time for NPs to meet the primary care needs of America’s medically disenfranchised populations. The lessons learned in Massachusetts underscore the urgency of this situation for the nation as a whole.15 After enacting statewide health reform in 2006, Massachusetts found itself unable to care for the hundreds of thousands of newly insured residents who quickly overwhelmed the state’s supply of primary care doctors. Further compounding this situation, restrictions against NPs practicing as primary care providers significantly hampered the state’s ability to care for its newly insured residents. Many MCOs across the state refused to credential NPs as primary care providers, leading the state to enact additional reforms requiring insurers to recognize NPs as primary care providers to address the problem of health care access.16

National health care reform can learn from the Massachusetts experience, including the problems that can arise if there is not an adequate medical community ready to care for the newly insured. NPs are valuable assets in the context of health care reform, and can play a critical role in helping to alleviate the problems stemming from a shortage of primary care physicians, such as those experienced in Massachusetts. However, MCOs continue to hold the key to equitable treatment for primary care NPs. As long as these payers undervalue the contributions of NPs, these health care providers will continue to be underutilized, despite being...
qualified to provide primary care at a lower cost and at equal quality to physicians. State and federal policy makers must act to remove regulatory and reimbursement barriers that prevent NPs from providing primary care.

This study has several limitations. Data were gathered from telephone surveys conducted with representatives of each HMO plan contacted. Though interviewers requested to speak with a representative knowledgeable about credentialing practices at each of the HMOs, it is possible that in some instances these representatives provided incorrect or inaccurate information. Interviewers were trained to probe for clarification of information, and in instances where there were concerns about the accuracy of information provided by an HMO representative, these data were excluded from the report. Another limitation of this report is that it may not reflect broader trends in credentialing by MCOs nationwide. These findings are limited to the MCOs with the largest HMO product lines. Although the sample includes representation from 258 of the nation’s largest managed care HMOs, the authors were unable to gather data from 166 HMOs they attempted to contact. Thus, the data detailed in this report may not be representative of all large managed care HMO plans. Finally, this study was limited to HMO product lines. Because credentialing policies may vary by product line, it is conceivable that the credentialing policies of MCO HMO product lines differ from those of other health plans offered by the MCOs.

Despite these limitations, this study provides an important snapshot of the current credentialing and reimbursement practices of many of the largest MCOs in the United States. The findings of this study suggest that MCOs are increasingly supportive of NPs as primary care providers, yet much more progress is needed if NPs are to play a crucial role in assuring access to primary care for all.

Author Disclosure Statement

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