Increasing the Workforce Capacity of Health Centers: Reimbursement and Scope of Practice

State Policy Report #54

NATIONAL ASSOCIATION OF Community Health Centers

April 2015

I. Introduction

Health centers are critical providers of care for underserved communities and vulnerable populations. Many of their patients are uninsured, underinsured, and have many complex health needs. With the changes in eligibility for health insurance coverage programs, and health care delivery system transformation, it is anticipated that there will be an increase in demand for health center services: primary, behavioral, and oral health care, and enabling services.[1] According to various studies, it is predicted that there will be a shortage of primary care doctors as well as surgeons and medical specialists in the United States by 2020.[2] Furthermore, health centers may be the only, or one of the few, providers of care in a community, as many providers may not accept uninsured or Medicaid patients due to low reimbursement rates, and other challenges, such as administrative burden and the complexity of patient needs.[3]

The transformation of systems to become accountable for the health of a community and the patient center medical home (PCMH) model as the primary care base for these systems means there is increasing competition for primary health care team members. This is coupled with the predictions of shortages of primary care physicians and medical specialists, resulting in increasingly difficult recruitment and retention challenges for health centers. Policy issues that health center providers face in caring for Medicaid and uninsured patients include the difficulty in securing funding for services provided by appropriately trained team members that are often non-billable or included in their payment rates and statutes that limit primary health care team members from practicing at the top of their training/certification/licensure. In this brief, we explore state policy options that have been implemented that can impact the workforce capacity of health centers.

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[1] Witgert, K.E. and Hess, C. Issues and Policy Options in Sustaining a Safety Net Infrastructure to Meet the Health Care Needs of Vulnerable Populations. National Academy for State Health Policy, October 2012.

[2] Physician Shortages to Worsen Without Increases in Residency Training, Association of American Medical Colleges, available at: https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf; American College of Physicians. Solutions to the Challenges Facing Primary Care Medicine. Philadelphia: American College of Physicians; 2009: Policy Monograph. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.); Projecting Supply and Demand for Primary Care Practitioners Through 2020. Bureau of Health Professions, National Center for Health Workforce Analysis, Health Resources and Services Administration, November 2013. Available at: http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/projectingprimarycare.pdf

[3] Decker, S.L. In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help. (2012) Health Affairs 31, 8: 1673-1679; Long, S.K., Physicians May Need More Than Higher Reimbursements to Expand Medicaid Participation: Findings From Washington State. (2013) Health Affairs 32, 9: 1560-1567.

II. The Supply and Demand

In a 2013 analysis of primary care workforce supply and demand, the Health Resources and Services Administration (HRSA) projected that while the number of primary care physicians (PCPs) is projected to grow by 8 percent, the demand is projected to grow by 14 percent.[4] Taking into account multiple factors that drive supply and demand, the report estimates a projected shortage of 20,400 primary care physicians by 2020. The report also analyzed the supply of Nurse Practitioners (NPs) and Physician Assistants (PAs), and concluded that the growth in the supply of NPs and PAs might be able to help mitigate shortages in physicians.

It is not yet clear how the Affordable Care Act has changed the health care workforce landscape; however, there are many issues to consider when addressing the need for greater workforce capacity in the safety net. As various studies note, having insurance doesn't guarantee access to care, and barriers include distance, cost and time, as well as language and culture. Some of the new challenges include outreach to and enrollment of newly eligible populations, and access to culturally competent and quality care to vulnerable populations, many of whom may have not had coverage before. Operating with limited funds, health center providers are already stretched and shortages of providers to serve this population will continue to be a challenge.

In an examination of the potential gaps between demand and capacity, researchers from George Washington University computed measures of potential Medicaid expansion and primary care capacity in 2011 for each state and DC.[5] They found that high rates of uninsured were correlated with lower primary care capacity, and that states that would face the greatest increase in Medicaid patients due to expansion would also face the greatest challenges. It was also noted that there will also be the additional effect of insurance coverage through the new health insurance exchanges, and that there could be differences in access based on local service areas.

Due to differences in demand and capacity by state, it is important to consider various state-specific plans to strengthen workforce capacity. Strategies that states have been exploring include revising regulations and policies that would incentivize the existing workforce to implement team-based care models.

III. Policy Options: Reimbursement and Scope of Practice

As noted in a National Academy for State Health Policy (NASHP) report, reimbursement policies that define who can provide billable services and regulations around scope of practice can greatly impact safety net providers.[6] For example, some Medicaid programs have been able to leverage the Medicaid rule change under fee-for-service reimbursement that would allow unlicensed practitioners to provide covered preventive services "recommended by a physician or other licensed practitioner…within the scope of their practice under State law."[7] By making it possible for practitioners other than those that can traditionally bill for services to provide care and be reimbursed, this rule change may make it possible to hire and retain other staff to provide many of these essential services.

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[4] Projecting Supply and Demand for Primary Care Practitioners Through 2020. Bureau of Health Professions, National Center for Health Workforce Analysis, Health Resources and Services Administration, November 2013. Available at: http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/projectingprimarycare.pdf

[5] Ku, L, Jones, K, Shin, P., Bruen, B., and Hayes, K. Perspective, The States' Next Challenge – Securing Primary Care for Expanded Medicaid Populations. (2011) N Engl J Med 364:6, pp 493-5.

[6] Witgert, K.E. and Hess, C., October 2012.

[7] 42 C.F.R. 440.130(c). See also: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf

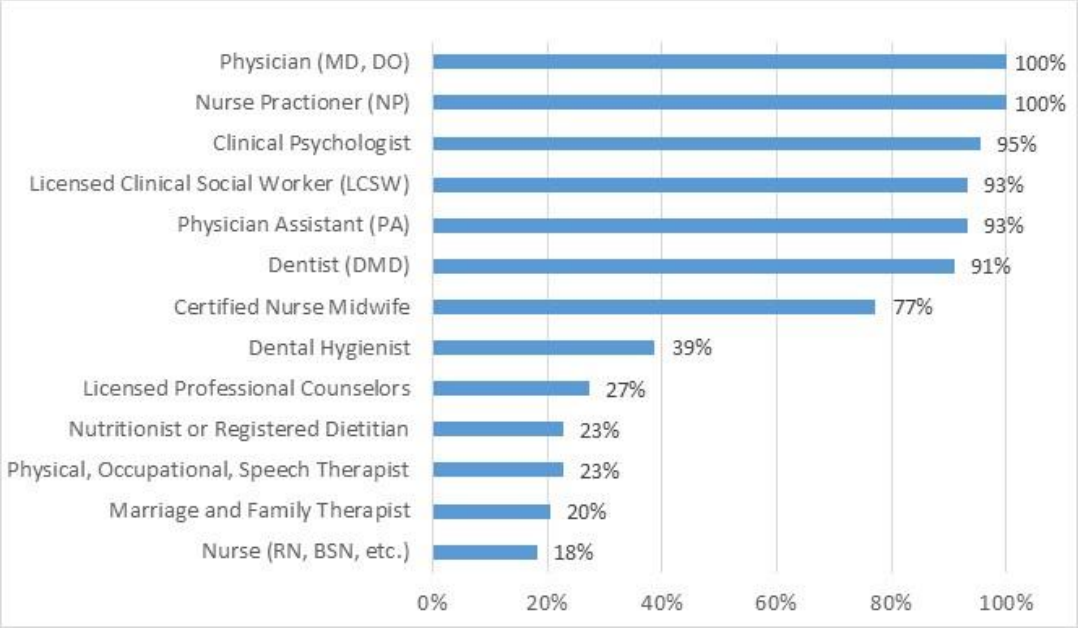
a. Provider Reimbursement and PPS

State laws and regulations can dictate what types of providers are able to submit claims for services. In many cases, a physician must deliver or supervise services to generate a billable encounter, which excludes all the services provided by other primary health care team members, and other essential services, such as care coordination and case management which may not be included or sufficiently reimbursed in payment methodologies.

Under the Prospective Payment System (PPS), as established by Congress in 2000 (see NACHC's PPS Report for more information), federally qualified health centers (FQHCs) are reimbursed at a per-visit baseline payment rate by Medicaid. This rate was established to take the average of the total reasonable costs and divide by the average of the total visits for a year. Thus, Medicaid would pay health centers their PPS rate for each face-to-face encounter between a Medicaid beneficiary and a billable provider for a medically necessary and covered service.[8] While Medicaid must pay for covered services provided by FQHCs, PPS payments vary by state with regard to the type of health care provider that can generate a billable encounter and the services that are included as part of the rate.

According to the results of a 2014 NACHC Survey of state primary care associations,[9] in addition to physicians and nurse practitioners, in most (but not all) of the responding states, physician assistants, licensed clinical social workers, clinical psychologists, dentists and certified nurse midwives can generate a PPS billable encounter. Some states that do not have a PPS rate for these providers may reimburse these services fee-for-service or through an alternative payment methodology. Less commonly, dental hygienists (35% of states), licensed professional counselors (29%) and nutritionists or registered dietitians (22%) are able to generate a PPS encounter. See **Figure 1,** and for state-by-state results, **Appendix A**.

Figure 1. States that can generate PPS encounters by provider type (percent respondents), n=44



[8] Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"), codified at 42 U.S.C. sec.1396a(bb)(1). See also NACHC Report for more information.

[9] NACHC conducted a survey of primary care associations in 50 states and the District of Columbia in July 2014. Forty-four PCAs responded to questions on PPS payments to providers. Respondents include PCA Executive Directors, CEOs or policy staff.

With regard to other critical health center services that are covered in the PPS rate, approximately a third of states responded that care coordination (15), and case management (17) are not reimbursable under any payment methodology. Furthermore, 25% (11) of the states responded that group visits, another strategy for increasing workforce capacity, are not reimbursable. See NACHC's 2014 Update on Implementation of the FQHC Prospective Payment System (PPS) in the States .

While bundled payment methodologies provide flexibility for health centers to include non-clinical services or different types of providers to be included in care teams, there is still the risk that payment does not cover the full cost of care. As a result, it is important to monitor and ensure that these new payment policies support the sustainability of health center programs that lead to high quality care and can provide all the services patients need.

b. Scope of Practice and State Licensing Regulations

Another approach to meeting demand has been the targeted expansion of scope and standards of practice for care team members who are not physicians. Generally, the scope of practice refers to procedures, actions, and processes that a healthcare practitioner is permitted to perform, and is defined by state boards of medicine, nursing, or other professional boards, often with instruction by the state legislature.[10] States can provide guidance on how providers are reimbursed by Medicaid, how they are licensed, what they are authorized to do (e.g. sign death certificates, or certify disability), where they can practice, and whether they can practice independently. State legislation has included authorizing the type of services that a specific practitioner can provide, allowing licensure or reimbursement of certain practitioners for specific services, or investing in training that would expand the role of that practitioner.

A study that looked at medical staffing patterns at health centers was conducted by researchers at George Washington University in 2015.[11] Results showed that nurse practitioner (NP) scope of practice laws are associated with staffing. In states that had full scope of practice for NPs, health centers had fewer physicians and more advanced-practice staff. In fact, health centers with more advanced-practice staff were often rural, and had more uninsured patients, suggesting they may be using a staffing model adjusted for limited resources. Although physicians had the highest level of productivity, the use of advanced-practice staff (nurse practitioners, physician assistants, and certified nurse-midwives) also increased the amount of care health centers could provide.

As outlined in a report developed by the National Conference of State Legislatures (NCSL), the various legislative considerations around scope of practice include independent practice authority, prescription and dispensing, licensure, education and training standards, and Medicaid payment.[12] While access to and quality of primary care services can be improved and costs can be reduced through the expansion of non-physician providers, revision of educational or licensure standards to ensure quality of care are also important considerations. In a scan of workforce legislation in the NCSL database from 2014 (see also **Appendix B** for chart of approved and pending bills), recent activity has included language to allow for greater independence of advanced practice nurses, such as adding the term "acute" to the type of conditions listed in the provisions governing a nurse practitioner's authorized practice stipulation in Nebraska.[13] In

[10] Ewing, J. and Hinkley, K.N. Meeting the Primary Care Needs of Rural America: Examining the Role of Non-Physician Providers, National Conference of State Legislatures, April 2013; available at http://www.ncsl.org/documents/health/RuralBrief313.pdf.
[11] Ku, L, Frogner, B.K., Steinmetz, E., and Pittman, P. Community Health Centers Employ Diverse Staffing Patterns, Which Can Provide Productivity Lessons for Medical Practices. (2015) Health Affairs 34, 1: 95-103.
[12] Ewing, J. and Hinkley, K.N., April 2013.
[13] NE L 243

Hawaii,[14] the state recognized the National Council of State Boards of Nursing's consensus model that would standardize educational requirements for certification and licensing of advance practice nurses that would facilitate the practice of nurses in different jurisdictions.

IV. Challenges and Opportunities

There are many different factors that contribute to the ability to meet the demand for health care services at health centers that include the supply of health care providers that practice at health centers, and a population with complex health conditions that is aging and becoming increasingly diverse. State policies, as well as national and local policies, that affect various aspects of how care is reimbursed and delivered, can have a profound impact on the ability of health centers to care for their patients especially in communities with limited resources. Additional resources on state workforce policies have been developed by various national organizations, such as the National Governors Association Center for Best Practices and the National Academy for State Health Policy.

In addition to reimbursement strategies and scope of practice laws, states have been involved with the recruitment and retention programs of all types of providers. These efforts have been focused particularly in areas with disparities in the distribution of the workforce, due to geography or the lack of providers willing to accept Medicaid or uninsured patients. To address this issue, NACHC has also developed a web-based toolkit that provides resources for recruitment, on-boarding, and retention programs for health centers.

Furthermore, regulations and legislation that govern the use of technologies for telemedicine or telehealth to increase access to both primary and specialty care are also being employed. In 2014, the American Telemedicine Association released several resources on state telehealth policies that include reports on best practices for Medicaid telehealth policies. Due to the complexity of the factors that influence the supply and demand for health center services, it is important for health centers to consider and implement new and multiple strategies to address health care workforce shortages in their communities.

[14] HI H 79, Act No. 2013-19

APPENDIX A. Medicaid Billable Providers at Federally Qualified Health Centers (from the 2014 NACHC PCA Survey):

State (N= 44)	Health Center Providers who can Generate a PPS Encounter													
	MD/DO	NP	PA	LCSW	CP	MFT	LPC	CNM	D	DH	POS	N	NRD	Notes:
AL	X	X	X	X	X				X					
AR	X	X	X	X	X				X	X				
AZ	X	X	X	X	X				X					
CA	X	X	X	X	X			X	X	X			X	Nutritionist or Registered Dietitian are only billable under the Comprehensive Perinatal Services Program (CPSP), other CPSP practitioners.
CO	X	X	X	X	X			X	X	X				Podiatrist
CT	X	X	X	X	X			X	X					
DC	X	X	X	X	X			X	X		X		X	
FL	X	X	X	X	X				X			X		
GA	X	X	X	X	X			X	X		X	X		
HI	X	X	X	X	X			X	X				X	Diabetes self-management
IA	X	X	X	X	X			X	X	X				
ID	X	X	X	X	X				X	X	X	X	X	
IL	X	X		X	X	X	X	X	X					Certified Nurse Anesthetist
IN	X	X	X	X	X			X	X	X				Podiatrist, Optometrist, Dental Hygienist under Dentist supervision
KS	X	X	X	X	X			X	X					RDH with ECP per the Kansas Dental Practice Act, RN for well-child nursing assessment
LA	X	X	X	X	X		X		X				X	
MA	X	X	X					X				X		
ME	X	X	X	X	X		X							
MI	X	X	X	X	X	X	X	X	X	X	X			
MN	X	X	X	X	X			X	X					Chiropractor
MO	X	X	X	X	X				X					
MS	X	X		X	X			X	X				X	
MT	X	X	X	X	X		X	X	X	X				Visiting Nurse, under certain circumstances
NC	X	X	X	X	X	X	X	X	X	X			X	
NE	X	X	X	X	X			X						
NH	X	X	X	X	X			X						
NJ	X	X		X	X				X					
NM	X	X	X	X	X			X	X					
NV	X	X	X	X	X			X	X		X			
NY	X	X	X	X	X			X	X	X	X			

	MD/DO	NP	PA	LCSW	CP	MFT	LPC	CNM	D	DH	POS	N	NRD	Notes:
OH	X	X	X	X	X		X	X	X	X	X	X		Optometrist
OK	X	X	X	X	X	X	X	X	X			X		Nurses limited to home bound services in certain cases. Services considered reimbursable encounters, including any related medical supplies provided during the course of the encounter. Any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted.
OR	X	X	X	X	X	X	X	X	X	X	X	X	X	
PA	X	X	X	X	X			X	X					Public Health Dental Hygiene Practitioner
RI	X	X	X	X	X	X		X	X	X				Licensed mental health counselor, clinical nurse specialist
SC	X	X	X	X	X			X	X					
TN	X	X	X	X	X			X	X	X				
TX	X	X	X	X	X		X	X	X					Optometrist
UT	X	X	X					X	X					LCSW, clinical psychologists, and other licensed professional counselors are billed to the county or local mental health authority and are not reimbursed at PPS rates.
VA	X	X	X	X	X	X	X	X	X					
VT	X	X	X	X	X			X						
WA	X	X	X	X	X	X	X	X	X	X		X	X	Nurses and registered dietitians can provide encounters through maternity support services program
WI	X	X	X	X	X			X	X	X	X			Optometrist, podiatrist, psychotherapist, chiropractor and substance abuse services
WV	X	X	X	X	X			X	X	X				

MD/DO: *physician or doctor of osteopathic medicine;* ***NP****: nurse practitioner;* ***PA****: physician assistant;* ***LCSW****: licensed clinical social worker;* ***CP****: clinical psychologist; MFT: marriage and family therapist;* ***LPC****: Licensed Professional Counselors;* ***CNM****: certified nurse midwife;* ***D****: dentist;* ***DH****: dental hygienist;* ***POST****: physical, occupational, speech therapist;* ***NRD****: nurse nutritionist or registered dietitian*

States that did not respond to this question: AK, DE, KY, MD, ND, SD, WY

Appendix B. Overview of Legislation (Enacted or Pending Only) from NCSL Scope of Practice Legislation Tracking Database (full database available at National Conference of State Legislatures, http://www.ncsl.org/research/health/scope-of-practice-legislation-tracking-database.aspx):

STATE	Scope of Practice Changes	Licensure or Reimbursement	Other
CA	Pending – CA S 491 Deletes a requirement that certain acts be performed pursuant to a standardized procedure or in consultation with a physician and surgeon. Authorizes a NP to examine patients, establish a medical diagnosis and prescribe drugs and devices.		
	Pending – CA S 492 Adds the provision of habilitative optometric services to the practice of optometry. Expands parameters of optometrists using therapeutic pharmaceutical agents by removing certain limitations on their practice. Deletes limitations on certain kinds of diagnostic tests.		
	Enacted – CA S 493, Act No. 469 Authorizes pharmacist to administer drugs and biological products that have been ordered by a prescriber. Expands other functions pharmacists are authorized to perform. Authorizes pharmacists to order tests for managing efficacy and toxicity of drug therapies.		
HI		Enacted – HI H 79, Act No. 2013-19 Recognized the National Council of State Boards of Nursing's advanced practice registered nurse consensus model and clarifies language related to advanced practice registered nurse educational requirements consistent with that consensus model.	

STATE	Scope of Practice Changes	Licensure or Reimbursement	Other
IL	Enacted – IL H 1052, Act No. 192 Removes references to a written collaborative agreement throughout the Act, provides that an advanced nurse practice nurse's scope of practice includes collaboration and consultation with or referral to a physician or other appropriate health-care professional for patient care needs that exceed the APN's scope of practice, education or experience.		
		Pending – IL S 1168 Provides for the licensure of naturopathic physicians.	
ME	Enacted – ME S 21, Act No. 6 Allows a pharmacist to administer a vaccine licensed by the U.S.FDA to a person 18 years of age or older who has a primary care physician or other existing relationship with a nurse practitioner or an authorized practitioner if the vaccine is outside the guidelines recommended by the U.S. CDC Advisory Committee on Immunization Practices if the prescription specifically states the vaccine is medically necessary.		
	Enacted – ME H 123, Act No. 98 Would allow a pharmacist to administer certain vaccines to a person 9 years of age or older according to a valid prescription. (see also ME S 21, Act No. 6)		

STATE	Scope of Practice Changes	Licensure or Reimbursement	Other
		Enacted – ME H 870, Act No. 575 Would establish a licensure process and scope of practice for dental hygiene therapists, requires the therapist to be supervised by a dentist licensed in this state.	
MI		Pending – MI S 2 Would establish license for nurse midwives, nurse practitioners and clinical nurse specials.	
		Pending – MI H 4152 Would provide for licensure of naturopathic physicians.	
NE	Enacted – NE L 243 Adds the term acute to the type of conditions listed in the provisions governing a nurse practitioner's authorized practice stipulation.		
NY	Pending – NY S 893 Would provide that chiropractors may perform certain services including certifying for disability.		
		Pending – NY A 4170 Would amend the Education Law, allows out-of-state licensed health care professionals to perform services in this state.	

STATE	Scope of Practice Changes	Licensure or Reimbursement	Other
	Pending – NY S 2068 Would amend the Public Health Law, authorizes a physician assistant, acting under the supervision of a physician, to sign death certificates in like manner as physicians, and imposes upon physician assistants the same duties that physicians have in connection therewith.		
		Pending – NY S 2183; NY A 2359 Would authorize certain health care professionals licensed to practice in other jurisdictions to practice in this state in connection with an event sanctioned by Remote Area Medical.	
			Pending – NY A 2247 Would establish standards to advance the management and treatment of chronic pain, incorporates continuing education programs for health care professionals that treat patients that have chronic pain.
	Pending – NY A 2253 Would provide that chiropractors may certify disability for handicapped parking and real property tax purposes and be employed by school districts to assist medical inspectors.		
	Pending – NY S 2254 Would authorize physician assistants under the supervision of a physician to perform most medical services that a physician can perform, including the signing of death certificates.		

STATE	Scope of Practice Changes	Licensure or Reimbursement	Other
	Pending – NY S 2309 Would allow the practice of registered professional nursing by a certified nurse practitioner to include diagnosis and performance without collaboration of a licensed physician.		
OK	Enacted – OK H 1461, Act No. 228 Permits Board of Nursing to issue prescriptive authority recognition by endorsement to certain individuals if certain requirements are met.		
VT			Enacted – VT S 59, Act No. 0048 Would establish a Direct Support Provider Workforce Council to advise the State regarding the recruitment and retention of such providers.

Search terms: All, 2014 (January 15, 2015)

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April 2015

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This publication was supported by Grant/Cooperative Agreement Number U30CS16089 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.