

Provider parity

NPS are advanced practice registered nurses prepared at the master's or doctoral level to provide primary, acute, chronic, and specialty care to patients of all ages and walks of life. Daily practice includes assessment; ordering, performing, supervising, and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment, including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients, their families, and communities. NPS practice in nearly every healthcare setting, including clinics, hospitals, Veterans Affairs, and Indian Health Care facilities, emergency rooms, urgent care sites, private physician, or NP practices (both managed and owned by NPSs), nursing homes, schools, colleges, retail clinics, public health departments, nurse-managed clinics, homeless clinics, and home health. NPS holds prescriptive authority in all 50 states and the District of Columbia. Notably, 86.6% of NPs are certified in primary care, the majority of whom see Medicare and Medicaid patients. NPS completes more than one billion patient visits annually.

A study of 26 capitated primary care practices with approximately two million visits by 206 providers determined that the practitioner labor costs and total labor costs per visit were lower in methods where NPs and physician assistants (PAs) were used to a greater extent. Based on a systematic review of 37 studies, Newhouse et al. (2011) found consistent evidence that cost-related outcomes such as length of stay, emergency visits, and hospitalizations for NP care are equivalent to those of physicians. In 2012, modeling techniques were used to predict the potential for increased NP cost-effectiveness in the future based on prior research and data. Using Texas as the model state, Perryman (2012) analyzed the potential economic impact associated with greater use of NPs and other advanced practice nurses, projecting over \$16 billion in immediate savings that would increase over time.

NP cost-effectiveness is not dependent on actual practice settings and is demonstrated in primary, acute, and long-term care settings. For instance, NPs practicing in Tennessee's state-managed managed care organization (MCO) delivered health care at 23 percent below the average cost associated with other primary care providers, achieving a 21 percent reduction in hospital inpatient rates and 24 percent lower lab utilization rates compared to physicians (Spitzer, 1997). A one-year study comparing a family practice physician-managed practice with an NP-managed practice within an MCO found that, compared to the physician practice, the NP-managed practice had 43 percent of the total emergency department visits, 38 percent of the inpatient days and 50 percent of total annualized per member monthly cost (Jenkins & Torrisi, 1995). Nurse-managed centers (NMCs) with NP-provided care have demonstrated significant savings, less costly interventions, and fewer emergency visits and hospitalizations (Hunter, Ventura, and Keams, 1999; Coddington & Sands, 2009). A study conducted in a large health maintenance organization (HMO) setting established that adding an NP to the practice could virtually double the typical panel of patients seen by a physician, with a projected increase in revenue of \$1.28 per member per month or approximately \$1.65 million per 100,000 enrollees annually (Burl, Bonner, and Rao, 1994).

Chenowith, Martin, Pankowski, and Raymond (2005) analyzed the healthcare costs associated with an innovative on-site NP practice for more than 4,000 employees and its dependents, finding savings of \$0.8 to \$1.5 million, with a benefit-to-cost ratio of up to 15-1. Later, they

tested two additional benefit-to-cost models using 2004–2006 data for patients receiving occupational health care from an NP, demonstrating a benefit-to-cost ratio ranging from 2-1 to 8.7-1, depending on the method (Chenoweth, Martin, Pankowski and Raymond, 2008). Time lost from work was lower for workers managed by NPS compared to physicians, as another aspect of cost savings (Sears, Wickizer, Franklin, Cheadle, and Berkowitz, 2007).

Several studies have documented the cost-effectiveness of NPs in managing the health of older adults. Hummel and Prizada (1994) found that, compared to the cost of physician-only teams, a physician-NP team at a long-term care facility was 42 percent lower for intermediate and skilled care residents and 26 percent lower for those with long-term stays. The physician-NP teams also had significantly lower rates of emergency department transfers, shorter hospital lengths of stay, and fewer specialty visits. A one-year retrospective study of 1,077 HMO enrollees residing in 45 long-term care settings demonstrated a \$72 monthly gain per resident, compared to a \$197 monthly loss for residents seen by physicians alone (Burl, Bonner, Rao, and Kan, 1998). Intrator (2004) found that residents in nursing homes with NPs were less likely to develop ambulatory care-sensitive diagnoses requiring hospitalizations. Bakerjian (2008) summarized a review of 17 studies comparing nursing home residents who are patients of NPs to others, finding lower rates of hospitalization and lower overall costs for NP patients. The potential for NPs to control costs associated with the health care of older adults was recognized by United Health (2009), which recommended that providing NPS to manage nursing home patients could result in \$166 billion in healthcare savings.

NP-managed care within acute-care settings is also associated with lower costs. Chen, McNeese-Smith, Cowan, Upenieks, and Afifi (2009) found that NP-led care was associated with lower overall drug costs for inpatients. When Paez and Allen (2006) compared NP and physician management of hypercholesterolemia following revascularization, they found that patients in the NP-managed group had lower drug costs while being more likely to achieve their goals and comply with the prescribed regimen.

Collaborative NP-physician management was associated with decreased length of stay and costs and higher hospital profit, with similar readmission and mortality rates (Cowan et al., 2006; Ettner et al., 2006). The introduction of an NP model in a health system's neuroscience area resulted in more than \$2.4 million in savings in the first year and a return on investment of 1,600 percent; similar savings and outcomes were demonstrated as the NP model was expanded in the system (Larkin, 2003). Boling (2009) cites an intensive short-term transitional care NP program documented by Smigleski et al. through which health care costs were decreased by 65 percent or more after enrollment, as well as the introduction of an NP model in a system's cardiovascular area associated with a decrease in mortality from 3.7 percent to 0.6 percent. More than 9 percent decreased cost per case (from \$27,037 to \$24,511).

In addition to the total cost, other factors are essential to healthcare cost-effectiveness. These include illness prevention, health promotion, and outcomes. (American Association of Nurse Practitioners, 2013)

PAs (physician associates/physician assistants) are licensed clinicians who practice medicine in every specialty and setting.

Trusted, rigorously educated, and trained healthcare professionals, PAs are dedicated to expanding access to care and transforming health and wellness through patient-centered, team-based medical practice.

Established in 1967, the PA profession currently has around 159,000 practitioners in the U.S., engaging in more than 500 million patient interactions yearly.

PA education and practice emphasize patient education, preventive care, and chronic care management. PAs' generalist medical training enables them to provide a broad spectrum of patient care and treat the "whole patient." For example, during an appointment with a PA working in cardiology, in addition to discussing the patient's heart issues, a PA might notice a skin condition and either treat it or refer that patient to a dermatology practice. PAs make it easier for patients to get the care they need when they need it. A 2014 Harris Poll found that 92 percent of Americans who have seen a PA or have a family member who has seen a PA said that having a PA makes it easier to get a medical appointment. (American Academy of Physician Associates, 2022)

PAs and nurse practitioners (NPs) are increasingly vital as front-line healthcare providers. Although there are some significant differences in training and maintenance of certification requirements, the similarities between PAs and NPs far outweigh the differences. What is essential for patients to know is that, regardless of whether they see a PA or an NP, they are being treated by a highly educated, well-trained healthcare provider who places the patient at the center of their care. (American Academy of Physician Associates, 2021)

According to a new Commonwealth Fund report, the United States ranks last among 11 industrialized countries on health system quality, efficiency, access to care, equity, and healthy lives despite having the most expensive healthcare system. The other countries included in the study were Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom. While there is room for improvement in every country, the U.S. stands out for having the highest costs and lowest performance—the U.S. spent \$8,508 per person on health care in 2011, compared with \$3,406 in the United Kingdom, which ranked first overall. (The Commonwealth Fund, 2014)

For example, for a moderate complexity follow-up visit (code 99214), an APRN or PA is reimbursed \$69.95 compared to \$105.45 for the same service, or 66% of the physician's reimbursement. (Nevada Advanced Practice Nurses Association, 2021)

Impacts of failure to provide Equity:

- Nevada is discouraging APRNs and PAs from choosing to practice in our state, creating less and slower access to primary and specialized care providers.
- Fewer Nevadans have access to a primary or specialty care provider who shares the same race, ethnicity, background, and life experience they do.

Solutions:

- Establish reimbursement parity in the State Medicaid budget for the next biennium.
 - Establish reimbursement parity within ERISA (self-funded) plans.
 - Meet NRS requirements for parity within insurance plans regulated by the Nevada Division of Insurance. (Nevada Advanced Practice Nurses Association, 2021)
- Provider parity will increase the pool of providers needed to deliver the necessary care to a population that continues to age and experience increasing comorbid medical conditions such as diabetes, hypertension, high cholesterol, and obesity.
- NPs and PAs are valuable resources for providing primary and specialty care. Entities need to have sufficient reimbursement to provide the same level of care and services.

Parity is equity:

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