HEALTH POLICY AND ADVANCED PRACTICE NURSING
IMPACT AND IMPLICATIONS
SECOND EDITION

KELLY A. GOUDREAU, PhD, RN, ACNS-BC, FAAN
MARY C. SMOLENSKI, EdD, MS, FNP, FAANP
EDITORS

Praise for the First Edition:
“There are many policy books, but none are written by APRNs or focus just on APRN practice....APRNs are at the core, or can be, if they use their practice knowledge and education to shape policy...[This] editors eloquently make the case that policy formation is a critical nursing skill.”
—Doody's Medical Reviews

The only book of its kind, this text offers a wealth of information about the role of all types of APRNs (NPs, CNSs, CNMs, and CRNAs) in influencing the development and application of health care policy in a wide range of specialties. Featuring nine completely new chapters, the second edition delivers an invigorated focus on developing policy that advocates for vulnerable populations and discusses how the incorporation of interprofessional education has changed and will continue to alter health policy in the United States and internationally. The text also discusses the evolving influence of the Patient Protection and Affordable Care Act (PPACA) and the implications of current and future health policy changes that will be impacting the practice of various APRN roles.

Authored by APRN luminaries who have been closely involved with health policy development, the text meets the requirements of the IOM report The Future of Nursing and the DNP Criteria V for the inclusion of health policy and advocacy in the curriculum. This “call to action” for APRNs is specifically designed for courses enrolling students from a variety of APRN trajectories, and includes content from all APRN role perspectives in every section.

New to the Second Edition:
• Emphasizes policy development advocating for vulnerable populations
• Discusses the current and future influence of interprofessional education on health policy in the United States and worldwide
• Addresses how health policy changes will impact the various APRN roles
• Includes nine new chapters on health policy and its effect on large systems, value-based purchasing, health care reform and independent practice, health policy implications regarding substance abuse/PTSD treatment, genetics, competency issues, and the International Council of Nurses

Key Features:
• Addresses role-specific policy needs of all four APRN roles and DNP’s
• Encompasses all requisite information about health care policy and reform in the United States and worldwide and its impact on advanced practice nursing
• Meets the requirements of IOM’s The Future of Nursing and DNP Criteria V
• Explains how and why APRNs can and should influence policy development
• Discusses implications of professionals not participating in health policy decisions
Health Policy and Advanced Practice Nursing
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Health Policy and Advanced Practice Nursing

Impact and Implications

SECOND EDITION

Kelly A. Goudreau, PhD, RN, ACNS-BC, FAAN
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This book is dedicated to the practitioners and students of nursing who seek to improve the health care environment. It is through your curiosity, perseverance, and advocacy that the world we know will change. We are hopeful that this book will assist you to see what it is, how it will impact your practice, and what may be in the future.
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As we develop the second edition of this book, the Patient Protection and Affordable Care Act (PPACA), more commonly known as Obamacare, celebrated its seventh anniversary. It had succeeded in providing millions of Americans with health care coverage who were uninsured and changed the landscape of the health care system. In the midst of this change that put major emphasis on health promotion and prevention as essentials, Advanced Practice Registered Nurses (APRNs) made many strides toward full practice authority and these successes continue. This second edition highlights many of these successes. In spite of successes, the “health” care system, which Dr. Loretta Ford addressed in the Foreword of the first edition, is teetering on the edge of reverting to a “sick” system. This is a perfect time and opportunity for nursing to help move health care from a “curative” culture to a true “culture of health” system. Individuals have tasted the benefits of a health promotion/disease prevention system and embraced its tenets. They are ready for more.

The past few years have kindled in the people of the United States and around the world a desire to become involved and speak up, whatever their views may be. In the United Kingdom, Brexit was a good example. In the United States and worldwide, rallies on January 21, 2017, post–presidential inauguration, spoke to a variety of concerns from health care, women’s issues, education, human rights, work issues, and the economy, to name a few. The worldwide universality of this outcry was remarkable, and it continues on a local level. Legislators are being bombarded with phone calls, letters, faxes, emails, and demonstrations at their offices and town halls. Technology has made it easier to have one’s voice heard but this desire for change comes from within. People want to be heard and impact policy change. Health care is now also at the forefront of these efforts. When looking at rankings for happiness on a world scale and factors that contribute to this, the countries that score near the top in several polls (Bloomberg and the World Economic Forum) all ensure health care coverage for their populations. The United States ranks 28th in the happiness factor in the 2016 World Economic Forum poll, not even near the top 10. Can it be that healthy people are happy, productive people?

People seem to be ready to take more control of their health care and have a need for knowledge and guidance. The second edition of this book continues to investigate how health policy impacts APRN practice and how, through practice,
APRNs can help improve the lives of their patients/clients. In the first section, efforts such as the J & J Campaign for Nursing’s Future and the Consensus Model are brought up to date to show the influence they have had on the nursing practice. The Institute of Medicine (now the National Academy of Medicine) report *The Future of Nursing* pushed for nurses to practice to the full extent of their education and progress toward the defined goals is outlined. A new chapter is presented on independent practice with a case study outlining how state legislative rulings can affect practice. The growing success of the Doctor of Nursing Practice (DNP) programs and graduates is discussed, showing the interest of nurses wanting to be involved and take on more responsibility, including health policy change. A new chapter under special populations provides a review of the evolution and impact of genetics and genetics health policy on APRN practice. A new research chapter titled “Connecting Research, the Research Agenda, and Health Policy” discusses how a research agenda can have a powerful influence on health policy from many perspectives. In Unit IV, organizational perspectives on health policy and APRN practice are updated while in Unit V, global perspectives on APRNs and credentialing are provided by international experts showing how advanced practice nurses are faring worldwide. Finally, the current state of practice for each of the APRN roles is presented.

APRNs have played a role in pushing for full plenary authority as well as contributing to changes to the health care system. Some practice efforts have been more successful than others. An example is well described in the last chapter of the book by Zambricki on Certified Registered Nurse Anesthetists’ (CRNAs’) efforts to gain full practice authority in the Veterans Affairs (VA) system. As she points out, this is not the time to burn bridges, sit back, or slow down. The same waters may need to be crossed more than once! If the health care system is truly to be a patient-centered system, a culture change needs to happen. If it is to be a patient-choice system, individuals need to be aware of the options open to them, educated about their care including health promotion/prevention and the evidence to support this, and be knowledgeable of the consequences of their choices. Who better to play an integral part in making that happen than APRNs and nurses whose education and roles are grounded in health and well-being, and who better to push for policy changes in the health care system that support patient-centeredness, but APRNs? It is uncertain at this time what changes and deletions may be made to the PPACA with the new Congress or how individual states may deal with these changes. It is also unclear how this will impact APRNs and their practice. All the more important then it is to keep up to date about health policy issues, learn how to interact with lawmakers for positive change for our patients and our practices, and become involved. It is only through a concerted, coordinated effort that as APRNs we can help create a health-oriented culture and address the issues of access, quality, and affordability in our health care system.

Hopefully, this book will help the faculty guide graduate students toward a better understanding of the importance of health policy change and its widespread impact and guide students in taking an active role in these changes. In addition to the book, we have prepared an instructor’s manual of PowerPoint slides. Qualified instructors can obtain a copy of these by emailing textbook@springerpub.com. The timing is right, and people are ready for the change. Let’s grab the opportunity and make an impact!

Kelly A. Goudreau
Mary C. Smolenski
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To my husband, Serge Goudreau, who has been my personal rock during this past year. Thank you does not seem to say enough . . . but thank you.
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Health Policy and Advanced Practice Nursing: Impact and Implications, Second Edition
Funding of APRN Education and Residency Programs

Suzanne Miyamoto

A HISTORICAL PERSPECTIVE

The political roots for nursing education funding can be traced back to the administration of President John Adams when the Public Health Service (PHS) was created in 1798 (Kalisch & Kalisch, 1982). To this day, nurses are a vital part of the PHS and the use of health care professionals to provide public services spans the centuries as well as the investment by the federal government. In 1902, the U.S. PHS was established and eventually the Division of Nursing (Kalisch & Kalisch, 1982), currently housed within the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) and recently renamed the Division of Nursing and Public Health.

However, the nation’s attention to the importance of nurses became increasingly evident during World War I. Nurses who were a part of the PHS were deployed to military camps and asked to care for the civilian populations around the camps by teaching proper sanitation, treating children, and investigating communicable diseases (Kalisch & Kalisch, 1982). The care these nurses provided during wartime demonstrated the critical importance of public health nursing.

In general, the public health expenditures of the 1920s proved that public health nursing could be a purchasable commodity: the public health nursing programs, which had grown up in the first quarter of the 20th century, had helped to lower the mortality rate, to increase life expectancy and reduce significantly the morbidity rate from tuberculosis, typhoid fever, smallpox, malaria, and most infant diseases. (Kalisch & Kalisch, 1982, p. 170)

The Great Depression, the next chapter in U.S. history, caused federal funding for PHSs to be slashed. In 1933, the New Deal allowed the federal government to invest in programs that were cut during the Great Depression, which included nursing. Congress established the Federal Emergency Relief Administration and
the Civil Works Administration, which significantly invested in nursing (Kalisch & Kalisch, 1982). It was during this era that the federal government provided postgraduate training for public health nurses. Yet, one of the most notable federal investments for nursing education policy came in the 1940s. The United States had entered World War II and again, the call for nursing care had intensified.

During this time, the PHS funded a national nursing survey and allocated dollars to support nursing programs for the imminent increase in students. This work was conducted by the Nursing Council for National Defense that was created by the nation’s nursing leaders (Kalisch & Kalisch, 1982). A total of $1.2 million was allocated for basic training and administered by the Public Health Nursing section of the Division of States Relation of the PHS. This marked the first federal investment in nursing education. But it was the creation of the U.S. Cadet Nurse Corps in 1943 that established more comprehensive funding for nursing education (Kalisch & Kalisch, 1982).

Nurses were being drafted to serve in the military and this in turn led to a shortage of nurses in civilian hospitals, marking the first American nursing shortage. Given this demand for nurses in both the military and civilian sectors, proposals were offered to shorten nursing education programs. However, they were strongly opposed by nursing leaders as they feared a “massive collapse of the already meager educational standards” (Kalisch & Kalisch, 1982, p. 173). The initial objections were quickly overshadowed by the great need for nurses. In 1943, the U.S. Cadet Nurse Corps was introduced by Congresswoman Frances Payne Bolton (R-OH) and signed into law by President Roosevelt on June 15 of that year. Nursing students entering this 24- or 30-month program received free tuition, a monthly stipend, and uniforms. To oversee the corps, the PHS Surgeon General created the Division of Nursing Education (DNE). The U.S. Cadet Nurse Corps was the “largest experiment in federally subsidized education in the history of the United States up to that time” (Kalisch & Kalisch, 1982, p. 174).

The U.S. Cadet Nurse Corps was a major success, but the importance of this program as well as the DNE ended after the war. Congress viewed this particular federal investment as part of the war effort and phased out both programs. The result made a drastic impact on nursing school enrollments, and the nation’s hospitals experienced severe nursing shortages (Kalisch & Kalisch, 1982). Moreover, the effects created a shortage of nursing faculty, and many nursing leaders were concerned over the academic standards.

Ninety-seven percent of nursing education was hospital-based programs (Kalisch & Kalisch, 1982). The profession needed to investigate its trajectory. In 1948, the Carnegie Corporation and the Russell Sage Foundation sponsored the report Nursing for the Future (Kalisch & Kalisch, 1982). The recommendations included one that has withstood decades: nursing programs should be housed in colleges and universities and subpar programs should be closed. In 1948, the American Medical Association concurred with this recommendation through its Committee on Nursing Problems that investigated patient care standards and stressed the importance of nursing education at the baccalaureate level (Kalisch & Kalisch, 1982).

Although no major funding streams from Congress were appropriated for nursing education during this time, support on Capitol Hill was gaining momentum. As Kalisch and Kalisch (1982) note, “their [nursing legislation] recurring appearance before each session of Congress indicated that they had acquired a
permanent base of support” (p. 180). The only federal support for nursing from 1948 to 1956 was through the National Mental Health Act of 1946 that provided funding for psychiatric nursing education (Kalisch & Kalisch, 1982). The next major congressional action to support nursing education (beyond mental health nursing) was through the Health Amendments Act of 1956. In its first year, this legislation authorized $2 million in traineeships for approximately 3,800 nurses pursuing a career in education or administration (Kalisch & Kalisch, 1982). However, nursing leaders knew the piecemeal approach to funding nursing education would not be sufficient. The demand had surfaced for consistent federal funding for nursing education.

**CONGRESSIONAL ACTION TO ESTABLISH CONSISTENT FUNDING FOR NURSING EDUCATION**

The United States faced its second significant nursing shortage in the late 1950s and early 1960s as the nation’s hospitals reported high RN vacancy rates (Buerhaus, Staiger, & Auerbach, 2009). In 1961, the reported vacancy rate soared to 23.2% (Yett, 1975) much higher than the documented rates in the late 1990s and early 2000s. The shortage was driven by expanding positions for nurses in the hospital setting. As Kalisch and Kalisch (1982) noted:

> In the 1940s, hospitals had about one professional nurse for every fifteen beds and one practical nurse, or other auxiliary, for every ten beds. By the 1960s, one professional nurse was required for every five beds and one auxiliary for every three beds. Health care was given to a greater variety of people, and the primary focus of care had shifted from the home to the institution. (p. 186)

The nursing shortage impacted quality nursing care. Without the supervision of licensed RNs, nonprofessional personnel were providing direct patient care, resulting in dangerous errors (Yett, 1966). The impact of the nursing shortage on patient care was quickly rising to the national agenda. Its effects were highlighted in medical, nursing, and public health journals, in magazines and public newspapers (Yett, 1966). As cited by Yett, “Gradually, and inevitably, an awareness of this situation has become a part of what John Kenneth Galbraith so aptly has described as our ‘conventional wisdom’” (p. 190). The RN vacancy rate was on the rise from 5% in the 1940s to 10% to 15% in the 1950s and eventually 20% in the 1960s (Yett, 1966). It was at this time in history that hospitals lobbied Congress to enact legislation that would fund nursing education and help address the demand for nurses (Buerhaus et al., 2009).

In 1963, the Surgeon General released the report *Toward Quality in Nursing, Needs and Goals* (Congressional Research Service [CRS], 2005). This report signified the need for comprehensive legislation for nursing workforce development. It recommended that the supply of practicing RNs be increased to 850,000 by 1970, a growth of 55%. It also recommended that nursing school graduates increase by 75% to meet this goal and more specifically noted that nurses with graduate degrees should increase by 194%, baccalaureate prepared nurses by 100%, and licensed practical nurses by 50% (Kalisch & Kalisch, 1982).

The Nurse Training Act (NTA) of 1964 (P.L. 88–581) established Title VIII of the Public Health Service Act (PHSAA), which is known today as the Nursing
Workforce Development programs. While the legislation authorized a total of $238 million for five programs over 5 years, when it was signed into law by President Johnson on September 4, 1964, it received $9.92 million in its first year (Kalisch & Kalisch, 1982). “On signing the act, President Johnson observed that the Nurse Training Act of 1964 was the most significant nursing legislation in the history of the country” (Kalisch & Kalisch, 1982, p. 188). Further, “he believed that it would enable the nation to attract more qualified young people to this ‘great and noble calling’ ” (Kalisch & Kalisch, 1977, p. 855).

The five programs included nursing student loans, professional nurse traineeships, construction grants, project grants, and formula grants to diploma schools (Scott, 1967; see Table 12.1).

To administer the new authorities, the Division of Nursing created the Nursing Education and Training Branch (Kalisch & Kalisch, 1982). The programs made a significant impact. Between the years 1964 and 1967, the Nursing Student Loan program supported over 32,000 nursing students (Scott, 1967). The Professional Nurse Traineeship program was expanded to include long-term and short-term traineeships for graduate nurses seeking a clinical specialty track, and from 1964 to 1967 a total of 17,000 RNs were supported (Scott, 1967).

The other Title VIII programs focused more on the didactical and the “brick and mortar” of nursing education. Scott (1967) noted that the construction grants were established to help address the overcrowding in the nation’s nursing schools and the obsolete buildings. Sixty-two schools were funded to renovate their buildings between 1964 and 1967, which resulted in 2,600 more students enrolled (Scott, 1967). In addition, nine new nursing schools were developed due to the construction grants. The project grants that were created by the NTA awarded 116 schools federal dollars and benefited 33,000 students (Scott, 1967). The grant money was used for projects such as investing in multimedia to enhance education and teaching students in the community, away from the hospital setting. The final program created through the NTA went to support a total of 414 diploma programs given the high costs incurred by the hospitals in administering them (Scott, 1967).

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<td><strong>PROGRAMS</strong></td>
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</table>

Nursing experts of the 1960s noted that the NTA would significantly help alleviate the nursing shortage. However, others felt the original projections made in 1963 to increase the profession to 850,000 practicing nurses were not achievable. Yett’s (1966) analysis of the NTA and the Surgeon General’s report revealed a discrepancy of 170,000 nurses. According to the Surgeon General’s Consultant Group on Nursing, who wrote the 1963 report,

a feasible goal for 1970 is to increase the supply of professional nurses in practice to about 680,000 and that to meet this goal schools of nursing must produce 53,000 graduates a year by 1969 (including 13,000 baccalaureate, and an additional 3,000 at the master’s level). (U.S. Public Health Service, 1963 as cited in Yett, 1966)

Adding to the shortfall, Kalisch and Kalisch described in their 1977 unpublished study for the Division of Nursing that “It soon became obvious that unless the shortage of classroom and other training space in hospital schools of nursing and junior college nursing programs was corrected, it would stand in the way of the nation’s goal of having 680,000 nurses in active practice by 1970” (p. 834).

When the NTA was up for reauthorization in 1969, a committee was established to evaluate the five authorities. They found them to be effective in addressing the national nursing shortage through investments in nursing education but noted the NTA should be expanded to address planning, recruitment, and research (Kalisch & Kalisch, 1982). Congressional hearings were held on the NTA and other legislation supporting health professionals to determine how to act on the recommendations of the various committees. The Health Manpower Act of 1968 reauthorized the NTA. The reauthorization weakened the accreditation standards (the original bill required accreditation by the National League for Nursing, which, at the time only accredited baccalaureate programs, weakening federal support for diploma programs) due in large part to the associate degree lobby, but it did increase the number of scholarship provisions (Kalisch & Kalisch, 1982).

In the 1970s and 1980s, the Title VIII programs saw a number of amendments and reauthorizations. The NTA of 1971 (P.S. 92–158) and 1975 (P.L. 94–63), for the first time, provided grants for all types of nursing education programs (Kalisch & Kalisch, 1977). Known as capitation grants, they were “based on the well-established need to maintain the quality of education in schools of nursing by establishing a firm core of financial support” (Kalisch & Kalisch, 1977, p. 1135). Capitation grants provided formula grants based on enrollment rates in schools of nursing (American Association of Colleges of Nursing [AACN], 2008a). Schools were awarded the grants if they could demonstrate enrollment growth over the previous year and could use the funds to hire faculty, recruit students, enhance clinical laboratories, expand school of nursing buildings, or for other learning equipment (AACN, 2008a). For collegiate schools of nursing, Congress provided “$400 for each full-time baccalaureate student enrolled in the last two years of a nursing program, and approximately $275 for each student enrolled in an associate degree or diploma program” (AACN, 2008a, para. 3). Capitation grants received significant funding support from Congress and in fiscal years (FYs) 1977 and 1978 the program was appropriated $55 million (AACN, 2008b).

The capitation grant program proved to be a powerful source of funding for the nation’s nursing schools. However, politics played a significant role in its
eventual elimination. The program was endorsed by the liberal Congress, but not the conservative Nixon Administration. While President Nixon signed the NTA into law in 1971, continual debates between the Administration and Congress over the appropriate funding levels for nursing education led President Nixon to veto a number of bills that would have created higher levels of support (Kalisch & Kalisch, 1982). In 1972 and 1973, Congress passed continual resolutions (appropriations bills funded at the previous year’s level), but President Nixon impounded $73 million nursing appropriations that were later recovered through a federal court case (Kalisch & Kalisch, 1982). Funding for nursing education continued to be a target. In 1974, President Nixon’s budget request slashed the $160 million appropriated to Title VIII in 1973 to $49 million (Kalisch & Kalisch, 1982). Although Congress was able to secure funding for Title VIII above the president’s request and $139 million was finally appropriated for the NTA programs in FY 1974 (Division of Nursing, personal communication, May 2008), nursing would continue to fight for necessary federal support.

The Ford administration also made cuts to nursing education funding. President Ford vetoed the NTA of 1974, claiming it was too expensive (Kalisch & Kalisch, 1982). Additionally, the Administration felt that the nurse scholarship and loan programs were unnecessary as nursing students were eligible for other federal loans (Kalisch & Kalisch, 1982). The NTA of 1975 attempted to find a middle ground with the Administration. It decreased federal funding for the Title VIII programs but extended their authorization through FY 1978. However, the most notable difference of the NTA of 1975 was the creation of the Advanced Nurse Training program. This legislation provided funding for the expansion of master’s and doctoral nursing education programs, most notably those for Advanced Practice Registered Nurses (APRNs). President Ford vetoed this bill, but Congress was able to override his veto (Kalisch & Kalisch, 1982).

The nursing community fought with their congressional champions to keep the legislation intact and funded. When President Carter took office, he viewed the programs similarly to his predecessors, Presidents Nixon and Ford. He believed that nursing students could obtain funding from other federal programs, the NTA had helped address the nursing shortage, and the funding levels were too excessive (Kalisch & Kalisch, 1982). In President Carter’s fiscal year 1978 budget, he provided no funding for nurse training “and foreboded the probable end of the Division of Nursing had his administration continued” (Kalisch & Kalisch, 1977, p. 1225). Congress did pass an extension to the NTA in 1978, but it was pocket-vetoed on November 11, 1978, by President Carter (Kalisch & Kalisch, 1982). This move ignited outrage from the nursing community.

The following year, a new version of the legislation was drafted. It required a national study to be conducted by the Institute of Medicine (IOM—now, National Academy of Medicine) to determine if the federal government should continue to provide institutional support, if there was an actual nursing shortage, if the government should subsidize all of a nursing student’s loan, and how Congress should address the unequal distribution of nurses and the increase in nursing specialization (CRS, 2005). The NTA of 1979 was signed into law by President Carter on September 29 of that year given the provision of the study (Kalisch & Kalisch, 1982). The IOM report, Nursing and Nursing Education: Policies and Private Actions, found that federal support for the “overall supply of nurses was not needed, but that generalist education programs should continue to help sustain the nursing
supply” (CRS, 2005, p. CRS-2). The results of the report caused further cuts to the Title VIII programs and eliminated the construction grants, capitation grants, and scholarships at schools of nursing. Laws passed in 1981 and 1982 repealed most of the programs that were created in the 1960s and 1970s (CRS, 2005).

CURRENT FEDERAL FUNDING FOR APRNs

As noted through arguments mentioned previously by various political leaders, the reality is that nursing students, including APRN students, as well as all other health professions or college students can receive federal financial support from varying sources, particularly those that are funded by the U.S. Department of Education. Pell grants, Public Service Loan Forgiveness, Graduate Assistance in Areas of National Need, and Stafford Loans, are to name only a few (AACN, 2016b). Others are included in the U.S. Department of Labor that focuses more on technical needs and demand areas. This chapter continues to focus on dedicated funding for nurses or programs focused on health professionals. Like other health disciplines, particularly medicine and Graduate Medical Education, dedicated funding is critical to workforce training and sustainability. With that said, despite the political battles the Title VIII Nursing Workforce Development programs faced over the years, they still represent the largest dedicated source of federal funding for nursing education (Nursing Community, 2016). They also continue to support APRNs through consistent funding.

To date, the Title VIII programs have seven authorities: (a) Advanced Education Nursing (AEN) grants (Sec. 811); (b) Nursing Workforce Diversity (Sec. 821); (c) Nursing Education, Practice, Quality, and Retention (Sec. 831); (d) Nursing Student Loan program (Sec. 835); (e) Nurse Loan Repayment and Scholarship program (Sec. 846)—Renamed NURSE Corps; (f) Nurse Faculty Loan Program (Sec. 846A); and (g) Comprehensive Geriatric Education Grants (Sec. 855). Each of these programs has the potential to support APRNs. However, one major program within Title VIII focuses on APRN training, the AEN grants.

AEN grants (Sec. 811 of the PHSA) are modeled after the traineeship programs that were originally created in the 1960s and 1970s. There are three distinct programs authorized under this section. First, they provide schools of nursing, academic health centers, and other nonprofit entities funding to improve the education and practice of Nurse Practitioners (NPs), Certified Nurse-Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), Clinical Nurse Specialists (CNSs), nurse educators, nurse administrators, public health nurses, and other nurses pursuing AEN (P.L. 107–205).

Second, they provide full or partial traineeship support for graduate nursing students to help with the expense of tuition, books, program fees, and other reasonable living expenses (P.L. 107–205). This program is known as the Advanced Education Nursing Traineeships (AENT). Finally, the AEN section of Title VIII also funds the Nurse Anesthetist Traineeship (NAT), which provides the same type of support as the AENT to students in nurse anesthetist programs. As seen in Table 12.2, funding for the AEN programs represents a substantial portion of Title VIII funding. The average percent of funding allocated for the program over the last decade and a half is approximately 36%. The increase in funding seen after 2002 can be attributed to the enactment of the Nurse Reinvestment
Act of 2002 in which a number of new programs were added to Title VIII, which impacted future allocations.

In 2010, the Patient Protection and Affordable Care Act (P.L. 111–148) was signed into law and the subsequent appropriations cycles increased funding levels, but later, due to political battles between a Republican Congress and the Obama administration the funding fell. These cuts were to all nondefense discretionary programs as a result of negotiations around the debt ceiling or the fiscal cliff in 2011. A number of laws were passed, the Budget Control Act of 2011 (P.L. 112–125) and the American Taxpayer Relief Act of 2012 (P.L. 112–240), that included sequestration, across-the-board cuts to discretionary spending in fiscal years 2013 and 2014, which negatively impacted Title VIII (AACN, 2012b). Continued debates on how to control national funding resulted in continuing resolutions and smaller across-the-board cuts, somewhat stabilizing federal funding.

Two additional sources of federal support for APRN education and training are funded through the National Health Service Corps (NHSC) and the U.S. PHS. The NHSC was created through the Emergency Health Personnel Act (P.L. 91–623) in 1970 (Politzer et al., 2000). The intent of the legislation was to create a program that would direct commissioned officers and civil service personnel to national health professional shortage areas (HPSAs). The health care

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>TOTAL TITLE VIII FUNDING (IN MILLIONS)</th>
<th>FUNDING FOR AEN (IN MILLIONS)</th>
<th>AEN OF TITLE VIII FUNDING (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>$92.74</td>
<td>$60.04</td>
<td>64.7</td>
</tr>
<tr>
<td>2003</td>
<td>$112.76</td>
<td>$50.17</td>
<td>44.5</td>
</tr>
<tr>
<td>2004</td>
<td>$141.92</td>
<td>$58.65</td>
<td>41.3</td>
</tr>
<tr>
<td>2005</td>
<td>$150.67</td>
<td>$58.17</td>
<td>38.6</td>
</tr>
<tr>
<td>2006</td>
<td>$149.68</td>
<td>$57.06</td>
<td>38.1</td>
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<tr>
<td>2007</td>
<td>$149.68</td>
<td>$57.06</td>
<td>38.1</td>
</tr>
<tr>
<td>2008</td>
<td>$156.05</td>
<td>$61.88</td>
<td>39.7</td>
</tr>
<tr>
<td>2009</td>
<td>$171.03</td>
<td>$64.44</td>
<td>37.7</td>
</tr>
<tr>
<td>2010</td>
<td>$243.87</td>
<td>$64.44</td>
<td>26.4</td>
</tr>
<tr>
<td>2011</td>
<td>$242.39</td>
<td>$64.05</td>
<td>26.4</td>
</tr>
<tr>
<td>2012</td>
<td>$231.01</td>
<td>$63.93</td>
<td>27.7</td>
</tr>
<tr>
<td>2013</td>
<td>$217.50</td>
<td>$59.94</td>
<td>27.6</td>
</tr>
<tr>
<td>2014</td>
<td>$223.84</td>
<td>$61.58</td>
<td>27.5</td>
</tr>
<tr>
<td>2015</td>
<td>$231.62</td>
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<td>27.5</td>
</tr>
<tr>
<td>2016</td>
<td>$229.47</td>
<td>$64.58</td>
<td>28.1</td>
</tr>
</tbody>
</table>

AEN, Advanced Education Nursing.

Source: American Association of Colleges of Nursing (2016a).
professionals were to provide primary care to those in rural and underserved areas. The goal was to ensure that after the health care professional finished a tour, he or she would find the work to be rewarding and would choose to stay and practice in the community (Redman, 1973, as cited in Politzer et al.). The first cohort of 20 commissioned officers began in 1972 and included two nurses. As the importance of this effort grew, the federal government established a scholarship and loan repayment program within the NHSC.

Based on each school year, the scholarship program provides financial support if health professional students agree to serve in a NHSC-approved site that is located in a HPSA. For each full or partial school year that is reimbursed, the program requires a minimum of a 2-year commitment (NHSC, 2016a). The NHSC scholarship program supports NPs and CNMs.

The loan repayment program offers three options for primary care providers. The NHSC loan repayment program is offered to primary care providers who seek to work in an approved NHSC site. The Students to Service Loan Repayment program provides loan repayment to medical students in their fourth year. Finally, the state loan repayment program is a “federally-funded grant program to states and territories that provides cost-sharing grants to assist them in operating their own state educational loan repayment programs for primary care providers working in health professional shortage areas (HPSAs) within their state” (HRSA, 2016b, para. 1). Currently, the NHSC loan repayment program funds primary care NPs, CNMs, and psychiatric CNSs.

As noted, the U.S. PHS began in 1798 under the Adams Administration and was designated as one of the nation’s seven uniformed services. Nearly a century later, in 1889, the Commissioned Corps was officially established. But it was in 1944 that the PHSA authorized nurses and other health professionals into the commissioned corps (Debisette, Martinelli, Couig, & Braun, 2010). In 1949, when the PHS was restructured, the chief nurse officer position was created with the rank of Assistant Surgeon General (Rear Admiral; Debisette et al., 2010). To a nurse in the U.S. PHS, like in the Army, Navy, and Air Force, loan repayment options are available.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: INVESTING IN APRN EDUCATION

Beginning in 2008, the health care community was deeply engaged and excited by the potential for health care reform. Discussion regarding massive and overarching changes to increase health care access, reduce expenditures, and improve quality resonated inside and outside the capital beltway. The nursing community was no exception. It would be through this legislative vehicle that they could achieve substantial and even monumental provisions that would invest in nursing education and practice with the ultimate goal of helping to meet the nation’s changing patient care needs.

One of the first coordinated efforts by the nursing community was the reauthorization of the Title VIII Nursing Workforce Development programs. On January 24, 2008, Senator Barbara Mikulski (D-MD), a longtime nursing champion, contacted nursing leaders and requested they develop a single document that detailed the priorities for a stand-alone Title VIII reauthorization bill (Nursing Community, 2008). Headed by AACN, a Title VIII
Reauthorization task force was created to develop the consensus document that Senator Mikulski’s office had requested. The nursing organizations around the table had a short deadline of 3 weeks to agree on a set of priorities and set them to paper. By the end of the first week, nursing organizations participating had to submit priorities and recommendations for the reauthorization. During the second week, the task force voted on which of the presented recommendations would be appropriate for a Title VIII reauthorization. The final week was spent drafting the recommendations and their accompanying rationale.

The document included one overarching principle, increase funding for Title VIII—all other principles were contingent on increased funding levels, and four guiding principles: (a) increase support for nurse faculty education, (b) strengthen specific resources for the education of APRNs and advanced education nursing, (c) increase efforts to develop and retain a diverse and professional nursing workforce for the transforming health care delivery system, and (d) increase efforts of HRSA and the Division of Nursing to release timely and more comprehensive data on the nursing workforce (Nursing Community, 2008).

This document was signed by 37 national nursing organizations such as the AACN, American Nurses Association, and major APRN organizations like the American Academy of Nurse Practitioners (AANP), the American College of Nurse Practitioners (ACNP; AANP and ACNP have now merged to become the American Association of Nurse Practitioners), the National Organization of Nurse Practitioner Faculties (NONPF), the American Association of Nurse Anesthetists (AANA), the American College of Nurse-Midwives (ACNM), and the National Association of Clinical Nurse Specialists (NACNS). It was presented to Senator Mikulski’s office and while a stand-alone bill to reauthorize Title VIII was not introduced, the document was used as a tool by the senator and the nursing community in preparing the Title VIII provisions that were included in the Patient Protection and Affordable Care Act or ACA (P.L. 111–148).

Near the end of May 2009, 29 national nursing organizations, led by AACN, came together and agreed on a set of statutory language changes to Title VIII. Two significant changes were important to future APRN education funding. First, the AEN grant program included a clause under Section 296j(f)(2) that stated, “The Secretary may not obligate more than 10% of the trainee-ships under subsection (a) of this section for individuals in doctorate degree programs” (“Title VIII Reauthorization,” 2009, p. 3). Education for APRNs and those seeking advanced education in nursing was changing. The doctorate of nursing practice (DNP) was gaining momentum across the country, and the data clearly indicated a need for more nurse faculty with doctoral degrees (“Title VIII Reauthorization,” 2009). This clause severely limited the nation’s nursing schools from supporting those who were enrolled in DNP or PhD programs. Second, under the AEN grant program, the definition of authorized midwifery programs was included to remain current with the changes in midwifery education. These provision changes were eventually included in the ACA.

In relation to the Title VIII AEN program, the Affordable Care Act also led to the development of the Prevention and Public Health Fund (Sec. 4002). The fund, administered by HHS, provided support for programs authorized by the PHSA that focused on public health, wellness, and prevention (P.L. 111–148). It was through this fund that HRSA had the authority to create the Advanced Nursing
Education Expansion (ANEE) grant program in 2010. According to HRSA’s 2010 funding opportunity announcement,

The program’s two purposes are (1) to increase the number of students enrolled full time in accredited primary care Nurse Practitioner and Nurse Midwifery programs and (2) to accelerate the graduation of part-time students in such programs by encouraging full-time enrollment. (p. 1)

In the rationale, HRSA noted

The need for primary care continues to grow because of expanded health care coverage for the uninsured and under-insured provided by the Affordable Care Act. The ANEE program will help meet this need by increasing the supply of primary care nurse practitioners and nurse-midwives. (p. 1)

The total amount of funding was $30 million over a 5-year period and 26 grants were made to schools of nursing across the country (InsideGov, n.d.). While the program was not funded again through the Prevention and Public Health Fund, the noteworthy investment and recognition by the federal government of the important role NPs and CNMs play in providing primary care was substantial.

However, one of the most significant investments made to APRN education through the passage of the ACA was the Graduate Nurse Education (GNE) Demonstration (Sec. 5509). This program amended Title XVIII of the Social Security Act (SSA) to provide up to five hospitals with reimbursement for the clinical training of APRNs (P.L. 111–148). The road to achieve this important provision for APRN education was long, and it demanded the attention of critical nursing champions and a strong coalition of health care expertise. Table 12.3 shows the growth in numbers of enrollments and graduates in all types of DNP programs from 2005 to 2015.

THE ROAD TO THE GNE DEMONSTRATION

To understand the development of the GNE demonstration, a historical base must be laid for mandatory APRN education funding. Mandatory funding for nursing education and attempts to secure mandatory funding for APRN education are long embedded in nursing’s history. In fact, mandatory funding for nursing education dates back to the creation of Medicare through Title XVIII of the SSA (Theis & Harper, 2004). Graduate Medical Education (GME) essentially reimburses hospitals for the care provided to Medicare patients by physician residents. Within GME, there also lies what is commonly known as pass-through dollars. These dollars fund nursing and other allied health prelicensure education programs (Theis & Harper, 2004). Section 413.85 of the SSA stipulates however, that these education programs can only be supported if they “are operated by providers as specified [hospitals], enhance the quality of inpatient care at the provider; and meet the requirements of paragraph of this section for state licensure or accreditation.” It is the first clause that clarifies GME pass-through dollars. The nursing programs have to be owned and operated by the hospital. Therefore, this funding has only been allocated to diploma programs and some CRNA programs operated by hospitals because of how nursing programs were administered in the 1960s (Aiken, Cheung, & Olds, 2009).
### TABLE 12.3 Advanced Practice Registered Nurses (APRNs) Enrollment and Graduations (2005–2015)

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment</th>
<th>Graduation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>Enrollment: 3,992 CNS, 20,965 NP, 544 CNM, 2,725 CRNA; Graduation: 1,035 CNS, 5,920 NP, 206 CNM, 840 CRNA</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Enrollment: 3,932 CNS, 23,980 NP, 771 CNM, 2,793 CRNA; Graduation: 1,031 CNS, 6,475 NP, 234 CNM, 844 CRNA</td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>Enrollment: 3,747 CNS, 26,802 NP, 797 CNM, 2,908 CRNA; Graduation: 1,073 CNS, 6,859 NP, 229 CNM, 981 CRNA</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>Enrollment: 3,768 CNS, 29,323 NP, 951 CNM, 3,247 CRNA; Graduation: 965 CNS, 7,613 NP, 251 CNM, 989 CRNA</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>Enrollment: 3,879 CNS, 33,182 NP, 759 CNM, 3,308 CRNA; Graduation: 930 CNS, 8,354 NP, 232 CNM, 1,087 CRNA</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>Enrollment: 3,424 CNS, 38,858 NP, 1,168 CNM, 3,690 CRNA; Graduation: 903 CNS, 9,633 NP, 327 CNM, 1,256 CRNA</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>Enrollment: 3,139 CNS, 43,475 NP, 1,272 CNM, 3,614 CRNA; Graduation: 871 CNS, 10,866 NP, 345 CNM, 1,289 CRNA</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>Enrollment: 2,557 CNS, 48,685 NP, 1,370 CNM, 3,653 CRNA; Graduation: 821 CNS, 12,785 NP, 398 CNM, 1,347 CRNA</td>
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<thead>
<tr>
<th></th>
<th>2013 Enrollment</th>
<th>2,020</th>
<th>56,496</th>
<th>1,377</th>
<th>3,532</th>
<th>187</th>
<th>5,064</th>
<th>72</th>
<th>556</th>
<th>142</th>
<th>2,196</th>
<th>7</th>
<th>142</th>
<th>329</th>
<th>7260</th>
<th>79</th>
<th>698</th>
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<tbody>
<tr>
<td>Graduation</td>
<td>761</td>
<td>14,416</td>
<td>398</td>
<td>1,261</td>
<td>9</td>
<td>377</td>
<td>16</td>
<td>51</td>
<td>24</td>
<td>530</td>
<td>5</td>
<td>16</td>
<td>33</td>
<td>907</td>
<td>21</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>Enrollment</td>
<td>1,616</td>
<td>63,143</td>
<td>835</td>
<td>3,231</td>
<td>98</td>
<td>7,181</td>
<td>96</td>
<td>912</td>
<td>119</td>
<td>2,358</td>
<td>11</td>
<td>89</td>
<td>217</td>
<td>9539</td>
<td>107</td>
<td>1001</td>
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<tr>
<td>Graduation</td>
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<td>16,257</td>
<td>306</td>
<td>1,321</td>
<td>7</td>
<td>573</td>
<td>19</td>
<td>72</td>
<td>29</td>
<td>708</td>
<td>8</td>
<td>35</td>
<td>36</td>
<td>1281</td>
<td>27</td>
<td>107</td>
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<tr>
<td>2015</td>
<td>Enrollment</td>
<td>1,320</td>
<td>68,671</td>
<td>1,582</td>
<td>2,890</td>
<td>115</td>
<td>8,906</td>
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<td>196</td>
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<tr>
<td>Graduation</td>
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<td>19,581</td>
<td>483</td>
<td>1,272</td>
<td>11</td>
<td>934</td>
<td>15</td>
<td>148</td>
<td>43</td>
<td>942</td>
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<td>54</td>
<td>1876</td>
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CNM, Certified Nurse-Midwives; CNS, Clinical Nurse Specialist; CRNA, Certified Registered Nurse Anesthetist; DNP, Doctorate of Nursing Practice; NP, Nurse Practitioner; PBDNP, post-baccalaureate DNP; PMDNP, post-master’s DNP.

Nursing’s advocacy to change the structure of this was most notable during the 1990s when the Clinton Administration was debating health care reform. Many dialogues ensued on how the American health care systems should be restructured, and nursing leaders were engaged in serious discussions concerning funding for nursing education. In the late 1990s, nursing and other health care leaders believed it was the opportune time to discuss changes to GME reimbursement. Specifically, that a portion of Medicare funding should be directed to APRN education. At that point in history diploma programs had been significantly phased out and most registered nurses obtained their nursing degree from an associate or baccalaureate program. As Aiken, Cheung, and Olds (2009) noted the “rationale for Medicare support for graduate nursing education is the same as the rationale for GME: namely, that nurses in graduate programs are providing significant clinical care to Medicare beneficiaries in hospitals and other settings” (p. w653). In 1997, the IOM released its report On Implementing a National Graduate Medical Education Trust Fund that made the recommendation that,

Nursing DME (direct medical education) should be structured like physician DME and be paid to sponsoring institutions for the support of advanced practice, graduate clinical trainees. This provision should be neutral with respect to the proportion of DME that has supported nursing; diploma, undergraduate nurse education support should be phased out in 4 years or less to allow present students to complete their training. (p. 16)

Inspired by national support for APRN education, AACN, ACNP, and NONPF released the Statement on the Redirection of Nursing Education Medicare Funds to Graduate Nurse Education on January 29, 1998. This document, intended for the National Bipartisan Commission on the Future of Medicare Graduate Medical Education Study Group, urged that Medicare dollars given to entry-level nursing education be directed to graduate nursing education and specifically APRN programs (AACN, 1998). The comprehensive document outlined the role of APRNs in health care delivery, educational trends of APRN students, nursing research demonstrating the effectiveness and high quality of APRN care, as well as citing outside support for the recommendation (AACN, 1998). The report noted that the Physician Payment Review Commission in 1995 and 1997 “recommended that advanced degree nursing programs operated by 4-year colleges and universities be eligible to receive Medicare funds that otherwise would be available only to hospital-operated programs” (p. 8). The Association of Academic Health Centers also supported the allocation of Medicare dollars to APRN education as well as the coalition that represented 11 national nursing organizations (AACN, 1998).

The battle to redirect the Medicare funding from entry-level nursing to APRN education continued in the early 2000s, as AACN’s department of government affairs urged Congress to make this change through a legislative fix. However, no action was taken and the health care reform discussions under the Obama Administration opened the door for a unified approach. In 2009, health care reform discussions were heating up and nursing wanted to ensure the best possible legislative results for the profession and America’s patients. One entity to join the campaign to demonstrate nursing’s vital role in improving the nation’s health care system was a collaboration between the Robert Wood Johnson Foundation and AARP. Together, these powerful health care voices formed a new entity called the Center to Champion Nursing in America (CCNA). Their goal was to work with the nursing community to help promote the exceptional
contributions of RNs to improve health care access and quality, while reducing costs. In May of 2009, AARP representatives met with nursing lobbyists to discuss the potential to secure mandatory funding for APRN education.

Initial dialogues began between AARP and AANP, AACN, AANA, ACNP, ACNM, NACNS, and NONPF. Throughout the spring and summer of 2009, they negotiated a proposal for the Medicare reimbursement for APRN education. This proposal was not to redirect the existing funding for nursing education, but a separate and distinct pot. While the nursing leaders clearly understood it would be ideal to direct the funding for APRN education to the schools of nursing, Medicare law was not structured for this type of funding allocation. Medicare reimbursed hospitals, not health professions schools. Therefore, when legislation was introduced in the Senate and House by Senator Deborah Stabenow (D-MI) and Representative Lois Capps, RN (D-CA), respectively, the bill directed the reimbursement of hospitals and affiliated schools of nursing for APRN education (S.1569, H.R. 3185, 110th Cong.). The legislation, titled Medicare Graduate Nursing Education Act, also clearly stated that the hospital must have an agreement with an accredited school of nursing offering APRN programs. Educational costs associated in the bill included faculty salaries, student stipends (if any), clinical instruction costs, and other direct and indirect costs (S.1569).

The coalition that worked to develop the legislation also grew to a total of 14 organizations including a number of specialty NP organizations. The next steps to secure this program included meeting with key committee staff of the Senate Finance Committee and the House Ways and Means Committee (these committees have jurisdiction over changes to Medicare) to include the Medicare Graduate Nursing Education Act in the final health care reform legislation. Eight months of intense negotiations with key House and Senate Committee staff, particularly Senate Finance Committee staff, proved successful. When the ACA was signed into law on March 23, 2010, by President Barack Obama, the GNE demonstration was included.

Due to necessary negotiations, the final GNE demonstration was not the original proposal that AARP and the nursing community agreed upon in the summer of 2009. Given the uncertainty of total funding, complexity of its structure, and the new model for the Centers for Medicare and Medicaid Services (CMS, which administers Medicare programs) a demonstration or test was created. Up to five hospitals would be selected and a total funding level of $200 million over a 4-year period would be allocated. The funding could only be used for the reimbursement of APRN training. The law clearly stipulated that

Qualified training means training that provides an advanced practice registered nurse with the clinical skills necessary to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of Title XVIII of the Social Security Act, or enrolled under part B of such title. (P.L. 111–1148, Sec. 5509)

According to the GNE solicitation, “Costs associated with the didactic training component as well as the costs for certification and/or licensure are not eligible for reimbursement under this Demonstration” (CMS, 2010, p. 3). As stipulated in the law, hospitals had to establish an agreement with at least one school of nursing and also had to include two or more nonhospital community-based care settings (P.L. 111–1148, Sec. 5509). Due to the fact that CRNA education is
almost exclusively administered in acute care settings, a waiver was included in rural and medically underserved communities where 50% of the education did not occur in a community-based care site.

On March 21, 2012, CMS announced the solicitation for proposals for the GNE demonstration program with a deadline of May 21, 2012. The GNE demonstration would be run through the Centers for Medicare and Medicaid Innovation, which was created through the ACA.

In its personal communication to AACN members on March 21, 2012, the association stated, “AACN, along with our colleagues in the APRN community and AARP, have been advocating for this program since its inception and are excited to see the long-awaited solicitation for proposals released” (P. Bednash, personal communication, March 21, 2012).

On the release of the solicitation, the coalition noticed a few problems with the program that would need to be corrected, and led by AACN, quickly advocated for their change. For example, DNP programs were excluded and there was confusion concerning APRN specialties. The solicitation was changed to allow only DNP programs where the students were not already licensed as APRNs. Essentially, post-masters DNP programs were not applicable (CMS, 2010). Both the GNE coalition and CMS held webinars to help inform the hospital and nursing community about the demonstration.

After the proposals were collected (a short extension was granted), the final models were chosen and announced on July 30, 2012. They included the Hospital of the University of Pennsylvania (Philadelphia, PA), Duke University Hospital (Durham, NC), Scottsdale Healthcare Medical Center (Scottsdale, AZ), Rush University Medical Center (Chicago, IL), and Memorial Hermann-Texas Medical Center Hospital (Houston, TX). While Duke and Rush University hospitals only included their affiliated school of nursing, the proposals from Arizona and Texas included four schools of nursing and Pennsylvania included nine schools (AACN, 2012a).

By all accounts, the GNE Demonstration was a remarkable achievement for the profession as it came together under true collaboration with partners outside of nursing and a unified voice. Today, the Demonstration has completed its cycle legislated by the law with a 1-year extension. While no official report has been sent to Congress (slated for October 2017 as mandated by law), presentations given by leaders of the demonstration’s work, particularly Dr. Linda Aiken, who lead the Hospital of the University of Pennsylvania, and convened the five sites, note the many benefits of the program and its impact on the community. With any demonstration, unintended consequences were inevitable, but did not outweigh the opportunity to increase the number of APRNs to serve the Medicare population. Stakeholders continue to investigate a new proposal that would create a larger scale, more sustainable program.

APRN RESIDENCIES

In 2010, the Robert Wood Johnson Foundation and the IOM released the landmark report, The Future of Nursing: Leading Change, Advancing Health. The report was regarded by the nursing community as monumental and quickly became the rationale and support for initiatives the profession had strived to achieve for decades. The key messages were not earth-shattering to the community. They
focused on nurses practicing to the full extent of their education and training, nurses achieving higher levels of education, nurses being full partners with their colleagues in health delivery reform, and improving workforce planning and data collection (IOM, 2010). In considering the education of nurses and APRNs, the report was clear that residencies are an important part of their training.

The Future of Nursing report noted that in 2002, The Joint Commission recommended the development of nurse residency programs—planned, comprehensive periods of time during which nursing graduates can acquire the knowledge and skills to deliver safe, quality care that meets defined (organization or professional society) standards of practice (IOM, 2010, p. 5). Historically, residency programs have been focused on the acute care setting, but as the report urged, residencies must be developed and evaluated outside the acute care setting (IOM, 2010). Increasing demand for nurses who practice primary care and serve those in the rural and underserved communities required more focus on developing highly skilled practitioners. Therefore, the following recommendation was included in The Future of Nursing report:

Recommendation 3: Implement nurse residency programs. State boards of nursing, accrediting bodies, the federal government, and health care organizations should take actions to support nurses’ completion of a transition-to-practice program (nurse residency) after they have completed a prelicensure or advanced practice degree program or when they are transitioning into new clinical practice areas. (IOM, 2011, p. 11)

The report recommended that all levels of nurses should receive a residency program after graduation and offered a number of tactics to achieve this goal:

- State boards of nursing, in collaboration with accrediting bodies such as the Joint Commission and the Community Health Accreditation Program, should support nurses’ completion of a residency program after they have completed a prelicensure or advanced practice degree program or when they are transitioning into new clinical practice areas.
- The secretary of HHS should redirect all Graduate Medical Education funding from diploma nursing programs to support the implementation of nurse residency programs in rural and critical access areas.
- Health care organizations, the HRSA and Centers for Medicare and Medicaid Services, and philanthropic organizations should fund the development and implementation of nurse residency programs across all practice settings.
- Health care organizations that offer nurse residency programs and foundations should evaluate the effectiveness of the residency programs in improving the retention of nurses, expanding competencies, and improving patient outcomes (IOM, 2011, p. 12).

The actions to achieve residency programs require a significant commitment by both public and private investors.

In November 2010, the CCNA launched the Campaign for Action. Their mission is “to promote implementation of recommendations in the IOM report, The Future of Nursing: Leading Change, Advancing Health” (CCNA, 2013, para. 2). The Campaign for Action established State Action Coalitions in which nursing, health care, and industry leaders have committed to implementing various portions of the report in their state. A number of state coalitions are working to implement the need for nurse residencies at all educational levels.
At the federal level, one initiative to fund APRN residencies was signed into law through the ACA. Section 5316, Demonstration Grants for Family Nurse Practitioner Training Programs, was an attempt to provide NPs with a 1-year residency after graduation from their program. These practitioners would provide primary care to those in Federally Qualified Health Centers (FQHCs) and nurse-managed health clinics (NMHCs). Grants would be awarded to eligible FQHCs and NMHCs to cover the cost of full-time paid employment and benefits of family NPs. The law authorized $600,000 for each grant and designated such sums as necessary for FYs 2011 and 2014 (P.L. 111–148, Sec. 5316).

However, like many programs and demonstrations created through the ACA, funding never came to fruition. An authorization does not equal an appropriation. When the Republicans took control of the House in 2010, new programs from the ACA were targeted, and in budget negotiations, many never saw an actual allocation. As time progressed, the debt ceiling intensified, and the Republicans took control of the Senate, making them in control of both congressional chambers, ACA programs and efforts came under continual scrutiny for effectiveness. Currently, the program has an expired authorization, making it harder to fund.

CONCLUSION

Funding for RN and APRN education has ebbed and flowed throughout history. New programs are developed given the nursing demand and phased out as they relate to the national agenda. Political factors have and will continue to play a large role in federal support for nursing education. However, nursing leaders have adapted and advocated based on the ever-changing dynamics. They have become savvier by seeking partners outside the profession and have truly invested in the importance of coalitions. For example, the work to achieve the GNE demonstration could not have been accomplished by one entity. Legislators need to know that the proposal or nursing policy is the will of the entire community, and in the best-case scenario, beyond nursing.

The health care system will continue to evolve and change. APRNs will be substantial players in ensuring access to the high-quality, cost-effective care that America’s patients deserve. However, it is clear that the nation will not meet its goals of an improved system if federal investments in health professions education, including nursing, are not a priority.

DISCUSSION QUESTION

1. Assume that all funding from the Federal government for GNE ceases. What impact will this have on nursing? On faculty? On the health care system?

REFERENCES

of Medicare Graduate Medical Education Study Group. Archives of the American Association of Colleges of Nursing.


National health spending is projected to continue to grow faster than the economy, increasing from 18% to about 25% of the gross domestic product (GDP) by 2037 (Congressional Budget Office, 2012). Federal health spending is projected to increase from 25% to approximately 40% of total federal spending by 2037 (Congressional Budget Office, 2012). These trends could squeeze out critical investments in education and infrastructure, contribute to unsustainable debt levels, and constrain wage increases for the middle class (Emanuel, 2012; Emanuel & Fuchs, 2008).

Although the influx of baby boomers increases the number of Medicare beneficiaries, growth in per capita health costs increasingly drives growth in federal health spending over the long term (Congressional Budget Office, 2012). This means that health costs throughout the system drive federal health spending. Reforms that shift federal spending to individuals, employers, and states fail to address the problem. The only sustainable solution is to control overall growth in health costs.

Although the Affordable Care Act (ACA) significantly reduced Medicare spending over the decade after its passage (Sisko et al., 2019), health costs remain a major challenge. To effectively contain costs, solutions must target the drivers of both the level of costs and the growth in costs—and both medical prices and the quantity of services play important roles. Solutions need to reduce costs not only for public payers but also for private payers. Finally, solutions need to root out administrative costs that do not improve health status and outcomes.
The Center for American Progress convened leading health policy experts with diverse perspectives to develop bold and innovative solutions that meet these criteria. Although these solutions are not intended to be exhaustive, they have the greatest probability of both being implemented and successfully controlling health costs. The following solutions could be implemented separately or, more effectively, integrated as a package.

**PROMOTE PAYMENT RATES WITHIN GLOBAL TARGETS**

Under our current fragmented payment system, providers can shift costs from public payers to private payers and from large insurers to small insurers (Reinhardt, 2011). As each provider negotiates payment rates with multiple insurers, administrative costs are excessive. Moreover, continued consolidation of market power among providers increases prices over time (Berenson, Ginsburg, Christianson, & Yee, 2012). For all these reasons, the current system is not sustainable.

Under a model of self-regulation, public and private payers would negotiate payment rates with providers, and these rates would be binding on all payers and providers in a state. Providers could still offer rates lower than the negotiated rates.

The privately negotiated rates would have to adhere to a global spending target for both public and private payers in the state. After a transition, this target should limit growth in health spending per capita to the average growth in wages, which would combat wage stagnation and resonate with the public. We recommend that an independent council composed of providers, payers, businesses, consumers, and economists set and enforce the spending target.

We suggest that the federal government award grants to states to promote this self-regulation model. States could phase in this model, one sector (e.g., hospitals) at a time. To receive grants, states would need to report measures of quality, access, and cost publicly, and would receive bonus payments for high performance. For providers, the negotiated rates would be adjusted for performance on quality measures, which should be identical for public and private payers.

Funding for research, training, and uncompensated care—currently embedded in Medicare and Medicaid payments—should be separated out and increased with growth in the global spending target. These payments must be transparent and determined through negotiations or competitive bidding.

**ACCELERATE USE OF ALTERNATIVES TO FEE-FOR-SERVICE PAYMENT**

Fee-for-service payment encourages wasteful use of high-cost tests and procedures. Instead of paying a fee for each service, payers could pay a fixed amount to physicians and hospitals for a bundle of services (bundled payments) or all the care that a patient needs (global payments).

Payers need to accelerate the use of such alternative payment methods. As soon as possible, both public and private payers should adopt the bundles for 37 cardiac and orthopedic procedures used in the Medicare Acute Care Episode Program (Cutler & Ghosh, 2012; Mechanic, 2011). The bundles also need to include rehabilitation and post-acute care for 90 days after discharge. Within
5 years, Medicare should make bundled payments for at least two chronic conditions, such as cancer or coronary artery disease. Within 10 years, Medicare and Medicaid should base at least 75% of payments in every region on alternatives to fee-for-service payment.

Together, these policies would remove uncertainty about transitions from fee-for-service payment, allowing sufficient time for investment in infrastructure and technology by payers and providers.

**USE COMPETITIVE BIDDING FOR ALL COMMODITIES**

Evidence suggests that prices for many products, such as medical equipment and devices, are excessive (Government Accountability Office, 2012). Instead of the government setting prices, market forces should be used to allow manufacturers and suppliers to compete to offer the lowest price. In 2011, such competitive bidding reduced Medicare spending on medical equipment such as wheelchairs by more than 42% (Centers for Medicare and Medicaid Services, 2012). The ACA requires Medicare to expand competitive bidding for equipment, prosthetics, orthotics, and supplies to all regions by 2016 (Patient Protection and ACA, 2010). We suggest that Medicare immediately expand the current program nationwide.

As soon as possible, Medicare should extend competitive bidding to medical devices, laboratory tests, radiologic diagnostic services, and all other commodities (Office of Management and Budget, 2008). Medicare’s competitively bid prices would then be extended to all federal health programs (Office of Management and Budget, 2011).

To oversee the process, we recommend that Medicare establish a panel of business and academic experts. Finally, we recommend that exchanges—marketplaces for insurance starting in 2014—conduct competitive bidding for these items on behalf of private payers and state employee plans.

**REQUIRE EXCHANGES TO OFFER TIERED PRODUCTS**

The market dominance of select providers often drives substantial price variation (Commonwealth of Massachusetts, 2011a, 2011b). To address this problem, insurers can offer tiered plans. These insurance products designate a high-value tier of providers with high quality and low costs and reduce cost sharing for patients who obtain services from these providers. For instance, in Massachusetts, one-tiered product lowers copayments by as much as $1,000 if patients choose from 53 high-value providers (Commonwealth of Massachusetts, 2011a, 2011b). We suggest that exchanges and state employee plans offer at least one tiered product at the bronze and silver levels of coverage. This requirement can be implemented by 2016 or sooner if feasible. To encourage participation in the tiered product, it must achieve a minimum premium discount. For instance, in Massachusetts, insurers must offer at least one tiered product with a premium that is at least 12% lower than the premium for a similar nontiered product (Commonwealth of Massachusetts, 2010).

Transparency and consumer education are essential (Sinaiko & Rosenthal, 2010). Quality and cost measures must be standardized and publicly disclosed, and standards must be set for how these measures are used to create tiers. Whenever
possible, quality measures should use data from all payers. Finally, in contracts between insurers and providers, clauses that inhibit tiered products must be prohibited.

REQUIRE ALL EXCHANGES TO BE ACTIVE PURCHASERS

If exchanges passively offer any insurance product that meets minimal standards, an important opportunity is lost. As soon as reliable quality reporting systems exist and exchanges achieve the adequate scale, it is critical that federal and state exchanges engage in active purchasing—leveraging their bargaining power to secure the best premium rates and promote reforms in payment and delivery systems.

The ACA provides bonus payments to Medicare Advantage plans with four- or five-star ratings on the basis of their performance on measures of clinical quality and patients’ experience (Health Care and Education Reconciliation Act, 2010). We recommend that exchanges adopt this or a similar pay-for-performance model for participating plans and award a gold star to plans that provide high quality at a low premium.

SIMPLIFY ADMINISTRATIVE SYSTEMS FOR ALL PAYERS AND PROVIDERS

The United States spends nearly $360 billion a year on administrative costs (Institute of Medicine [IOM], 2010), accounting for 14% of excessive health spending (Farrell et al., 2008). Section 1104 of the ACA requires uniform standards and operating rules for electronic transactions between health plans and providers (Patient Protection and ACA, 2010). Although plans must comply with these standards and rules, the law does not require providers to exchange information electronically.

First, we suggest that payers and providers electronically exchange eligibility, claims, and other administrative information as soon as possible. Second, public and private payers and providers should use a single, standardized physician credentialing system. Currently, physicians must submit their credentials to multiple payers and hospitals. Third, payers should provide monthly explanation-of-benefits statements electronically but allow patients to opt for paper statements. Fourth, electronic health records should integrate clinical and administrative functions—such as billing, prior authorization, and payments—over the coming 5 years. For instance, ordering a clinical service for a patient could automatically bill the payer in one step.

Most important, we recommend that a task force consisting of payers, providers, and vendors set binding compliance targets, monitor use rates, and have broad authority to implement additional measures to achieve systemwide savings of $30 billion a year (U.S. Healthcare, 2010).

REQUIRE FULL TRANSPARENCY OF PRICES

Prices for the same services vary substantially within the same geographic area (Commonwealth of Massachusetts, 2011a, 2011b). However, consumers almost never receive price information before treatment. Price transparency would
allow consumers to plan ahead and choose lower cost providers, which may lead high-cost providers to lower prices. Although price transparency could facilitate collusion, this risk could be addressed through aggressive enforcement of anti-trust laws.

Moreover, both private and public models can achieve meaningful price transparency without leading to collusion (Government Accountability Office, 2011). Aetna provides the price it negotiated with a specific provider to members through an internet website. Similarly, New Hampshire has a public website that provides the median price paid by an insurer to a specific provider on the basis of claims data.

It is important that all private insurers and states provide price information that reflects negotiated discounts with specific providers. The information should include one price that bundles together all costs associated with a service, individualized estimates of out-of-pocket costs at the point of care, and information on the quality of care and volume of patients so that consumers can make informed decisions by value.

In contracts between insurers and providers, many providers prohibit insurers from releasing price information to their members (Government Accountability Office, 2011). These so-called gag clauses and other anticompetitive clauses must be prohibited. Finally, we recommend that state insurance commissioners and exchanges collect, audit, and publicly report data on prices and claims.

MAKE BETTER USE OF NONPHYSICIAN PROVIDERS

Restrictive state scope-of-practice laws prevent nonphysician providers from practicing to the full extent of their training. For instance, 34 states do not allow Advanced Practice Registered Nurses (APRNs) to practice without physician supervision (Pittman & Williams, 2012). Making greater use of these providers would expand the workforce supply, which would increase competition and thereby lower prices.

We recommend that the federal government provide bonus payments to states that meet scope-of-practice standards delineated by the IOM. Medicare and Medicaid payments to nonphysician providers should allow them to practice to the full extent permitted by state law.

EXPAND THE MEDICARE BAN ON PHYSICIAN SELF-REFERRALS

Many studies show that when physicians self-refer patients to facilities in which they have a financial interest, especially for imaging and pathology services, they drive up costs and may adversely affect the quality of care (Medicare Payment Advisory Commission, 2009; Mitchell, 2012). Under the so-called Stark law, physicians are prohibited from referring Medicare and Medicaid patients to facilities in which they have a financial interest. However, an exception allows physicians to provide “in-house ancillary services,” such as diagnostic imaging, in their offices (42 C.F.R. § 411.355, 2011).

We believe that the Stark law should be expanded to prohibit physician self-referrals for services that are paid for by private insurers. In addition, the loopholes for in-office imaging, pathology laboratories, and radiation therapy should
be closed. Physicians who use alternatives to fee-for-service payment should be exempted because these methods reduce incentives to increase volume.

LEVERAGE THE FEDERAL EMPLOYEES PROGRAM TO DRIVE REFORM

The Federal Employees Health Benefits Program (FEHBP) provides private health insurance to 8 million federal employees and their families. Although the FEHBP has encouraged various reforms to improve the quality of care (U.S. Office of Personnel Management, 2012), it could be much more innovative.

We recommend that the FEHBP align with Medicare by requiring plans to transition to alternative payment methods, reduce payments to hospitals with high rates of readmissions and hospital-acquired conditions, and adjust payments to hospitals and physicians by their performance on quality measures. In addition, the FEHBP should require carriers to offer tiered products and conduct competitive bidding on behalf of plans for all commodities. Finally, the FEHBP should require plans to provide price information to enrollees and prohibit gag clauses in plan contracts with providers.

REDUCE THE COSTS OF DEFENSIVE MEDICINE

More than 75% of physicians—and virtually all physicians in high-risk specialties—face a malpractice claim over the course of their career (Jena, Seabury, Lakdawalla, & Chandra, 2011). Regardless of whether a claim results in liability, the risk of being sued may cause physicians to practice a type of defensive medicine that increases costs without improving the quality of care.

Strategies to control costs associated with medical malpractice and defensive medicine must be responsible and targeted. These strategies must not impose arbitrary caps on damages for patients who are injured as a result of malpractice. According to the Congressional Budget Office, arbitrary caps on damages would reduce national health spending by only 0.5% (Congressional Budget Office, 2009a, 2009b). Although such caps would have a barely measurable effect on costs; they might adversely affect health outcomes (Congressional Budget Office, 2009a, 2009b; Lakdawalla & Seabury, 2009).

A more promising strategy would provide a so-called safe harbor, in which physicians would be presumed to have no liability if they used qualified health-information-technology systems and adhered to evidence-based clinical practice guidelines that did not reflect defensive medicine. Physicians could use clinical decision-support systems that incorporate these guidelines.

Under such a system, the physician could use the safe harbor as an affirmative defense at an early stage in the litigation and could introduce guidelines into evidence to avoid a courtroom battle of the experts. The patient could still present evidence that the guidelines were not applicable to the particular situation, and the judge would still determine their applicability.

It is critical to develop guidelines with credibility. A promising step is an initiative called Choosing Wisely, in which leading physician groups released guidelines on 45 common tests and procedures that might be overused or unnecessary (Cassel & Guest, 2012). Given the important role of guidelines, physicians
who participate in developing them must be free from financial conflicts of interest.

CONCLUSION

These are the types of large-scale solutions that are necessary to contain health costs. Although many in the health industry perceive that it is not in their interest to contain national health spending, it is a fact that what cannot continue will not continue.

Americans, therefore, face a choice. Payers could simply shift costs to individuals. As those costs become more and more unaffordable, people would severely restrict their consumption of health care and might forgo necessary care. Alternatively, governments could impose deep cuts in provider payments unrelated to value or the quality of care. Without an innovative alternative strategy, these options become the default. They are not in the long-term interests of patients, employers, states, insurers, or providers.

We present alternative strategies to contain national health spending that allow Americans to access necessary care. Our approach addresses the system as a whole, not just Medicare and Medicaid. It is the path to rising wages, a sustainable federal budget, and the health system that all Americans deserve.

REFERENCES


Patient Protection and Affordable Care Act Public Law 111–148, 111th Congress, Section 6410 (2010).


