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Does Contracting with Managed Care Organizations Remain A Barrier for Nurse Practitioners?

EXECUTIVE SUMMARY

- ▶ Upon implementation of the Affordable Care Act (ACA), many managed care organizations (MCOs) initially increased their nurse practitioner (NP) contracting.
- ▶ This trend has not continued, potentially frustrating ACA efforts to expand primary care provider capacity.
- ▶ In this study, about 25% of the responding MCOs did not contract with NPs as primary care providers.
- ▶ Further, only 62.5% of respondent MCOs offering Medicaid products reported contracting with NPs as primary care providers, suggesting this will place a disproportionate burden on low-income patients seeking to access care.
- ▶ Findings from this study also have important geographic implications, suggesting the decision to contract with NPs is made individually, not necessarily influenced by the numbers of newly insured or available primary care physicians.

IN ITS FIRST YEAR of implementation, the Affordable Care Act (ACA) increased the number of insured by an estimated 8-11 million, decreasing those uninsured in the United States by 25%. Further, as state Medicaid expansion programs roll out, several million more Americans are expected to obtain health insurance coverage. In light of the increase of insured Americans, it is estimated that, in 2020, there will be a shortage of 45,000 primary care physicians (Kirch, Henderson, & Dill, 2012). Nurse practitioners (NPs) have the ability, if utilized to the full scope of their practice, to close this provider gap (Bauer, 2010; Cronenwett & Dzau, 2010; Kirch et al., 2012; Poghosyan, Lucero, Rauch, & Berkowitz, 2012).

Inability to contract with managed care organizations (MCOs), defined simply as health insurers

or third-party payers, is a barrier for NPs (Hansen-Turton, Ritter, & Torgan, 2008). Sustainability of NP-led primary care relies on MCOs contracting with NPs as primary care providers (Hansen-Turton, Ritter, Begun et al., 2006). Without contracting, NPs cannot be compensated sufficiently for care provision.

Managed care contracting is not solely driven by state practice acts and contracting policies can vary between different insurance plans within a state. Individual MCOs determine their policy for NP contracting depending on the market's demand for providers, which is highly variable (Hansen-Turton, Ritter, Begun et al., 2006). This study provides a comprehensive survey of MCO contracting practices relating to NPs, differentiating by product plans that are offered on the state and federal insurance exchange marketplace.

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Previous Studies

Although the terms *credentialing* and *contracting* have been used interchangeably at times, they have distinct and important differences. Credentialing is defined as “the process of checking the credentials of health care practitioners and facilities” (National Committee of Quality Assurance, 2014, para. 1). Conversely, contracting is a “legal agreement between a payer and a(n)...individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions” (Academy of Managed Care Pharmacy, 2017, para. 92).

Previous studies have focused on credentialing of NPs (Hansen-Turton, Ritter, Rothman, & Valdez, 2006; Hansen-Turton et al., 2008; Hansen-Turton, Ware, Bond, Doria & Cunningham, 2013), but the focus of this article is *contracting with* nurse practitioners as primary care providers, which has critical implications for access to primary care services. An NP could be credentialed by an MCO, but if he or she is not individually contracted with MCOs, then NPs are unable to be independently reimbursed for their services. This study is the first of its kind and specifically addresses MCO contracting practices.

Previous work from members of this research team focused on NP credentialing. In 2006, Hansen-Turton, Ritter, Begun and colleagues reported only 33% of MCOs credentialed NPs. This number increased to 53% of MCOs in 2007, with no difference in states with or without anti-provider discrimination laws (Hansen-Turton et al., 2008). These data are reflective of the fact anti-provider discrimination laws are enforced unevenly, enabling continued barriers to NP primary care practice. In 2011-2012, major MCOs were surveyed again, with 74% of MCOs reported credentialing NPs (Hansen-Turton et al., 2013). Thus, although MCOs reported NP credentialing increased from 2005-2012, in light of the passage of the ACA and the

establishment of state health insurance exchanges, a more appropriate concern is the practice of contracting with NPs.

The extent to which MCOs are contracting with NPs is particularly important in the context of the ACA rollout because the primary goal of the ACA is to improve healthcare access, lower costs, and enhance quality. MCO contracting practices have the potential to impact all three of these areas. The failure to contract with NPs limits patient access to NP-managed primary care services, and could restrict the capacity of NPs to partially alleviate the impending shortage of primary care physicians. Additionally, the cost of a NP office visit is about 20% less than an office visit to a physician (Eibner, Hussey, Ridgely, & McGlynn, 2009). By excluding these providers, MCOs are effectively preventing the realization of these cost savings. Finally, MCO contracting practices influence quality because of their effect on the continuity of care. Nurse practitioners who are denied MCO contracts may have to stop caring for patients insured by the MCO.

Methods and Analysis

With sponsorship and resources from the National Nursing Centers Consortium, a team of researchers, nursing faculty, and students was assembled. Team members identified MCOs by using a directory of health exchange participants and by systematically visiting websites of the non-federal/state-run health insurance exchange marketplaces. Targeted MCOs were those that offer different insurance product lines and that were available on the state insurance exchanges, inclusive of both state and federally run exchanges across all states and Washington, DC. Overall, 264 individually distinct MCOs met these criteria. The MCOs were divided by states and each of four team members was assigned specific states to survey.

Researchers then systematically called each MCO, requesting to speak with a contracting repre-

sentative at each organization. Upon reaching a representative who was qualified to answer questions specific to contracting and MCO operations, researchers administered a scripted survey (see Figure 1). The survey used in this study was replicated from a previous study (Hansen-Turton et al., 2013), with appropriate semantic changes made to reflect the industry shift from *credentialing* to *contracting*. The survey was reviewed for clarity and accuracy with two health insurance policy experts.

Phone interviews were conducted using scripted interviews from the survey questions in Figure 1. There was no deviation from the script by team members. Data were recorded on a standardized form and specific individualized contact information for the MCO contracting representative was documented. If team members were unable to reach an MCO or an appropriate representative knowledgeable of the MCO's contracting practices, the MCO was called back 1 week later. MCOs were contacted a maximum of three times each. If no contact was made in three attempts, the MCO was designated “no response.”

Researchers met periodically to troubleshoot and discuss progress with contacts and discrepancies in data. During a periodic team meeting, researchers decided they wanted additional information from those MCOs that reported contracting with NPs. The team sought additional information to determine if those MCOs who reported contracting with NPs as primary care providers varied their contracting practices with NPs across different product line levels (catastrophic, bronze, silver, gold, platinum levels, and between Medicare and Medicaid products). Using each MCO contracting representative's contact information that was recorded during initial contact with the MCO, researchers then conducted a second round of calls to collect additional data. Supplementary scripted survey questions can be found in Figure 1.

Figure 1.
Scripted Survey

| |
|---|
| 1. Does your managed care organization contract with nurse practitioners as primary care providers? |
| If Yes to #1: |
| 1a. Are there restrictions to your managed care organization's contracting with nurse practitioners? |
| 1b. With which insurance products do you contract with nurse practitioners? (Medicare, Medicaid, Exchange products)* Which level(s) of exchange products? (Platinum, Gold, Silver, Bronze, Catastrophic, Doesn't Apply)* |
| 1c. Does your managed care organization contract with nurse practitioners in other capacities? |
| 2. Does your managed care organization reimburse nurse practitioners at the same rate as other primary care providers? |
| 3. Does your provider directory list all nurse practitioners that you contract with? |
| If Yes to #3: |
| 3a. Are they listed as nurse practitioners, primary care providers, or in another category? |

*Denotes questions that were added to the initial survey, as detailed in the article.

Once raw data were collected, two researchers assigned a coding schema to the information so that it could be analyzed electronically. Raw data were entered into a master Excel spreadsheet. Any discrepancies with the data coding were discussed with the full team to determine a final coding resolution. During data collection, some MCOs merged and/or ceased operations, resulting in the deletion of four MCOs (0.3%) from the overall survey population ($N=264$).

Data from the spreadsheet were uploaded into SPSS (version 19.0) and, again, crosschecked across the research team for accuracy in coding. Additionally, qualitative comments provided by MCO representatives were entered into a separate file for data enrichment. Data were analyzed using descriptive statistics and cross tabulations to determine overall similarities and differences among MCOs that did and did not report contracting with NPs as primary care providers.

Results

Overall, 81.1% ($n=214$) of MCOs were successfully contacted and two MCOs declined to participate in the study. Thus, 212 MCOs provided answers suffi-

cient to be considered participants in this study. This is roughly consistent with the participation rate in previous MCO studies conducted by the research team. All states and Washington, DC, were represented at least partially by respondent MCOs in the dataset.

Of the 212, 75% ($n=159$) reported contracting with NPs as primary care providers at least some of the time. Only two states, Indiana and West Virginia, had no participating MCOs that reported contracting with NPs. All MCOs in Alaska, Arkansas, Maine, Missouri, New Mexico, North Carolina, North Dakota, New Hampshire, Rhode Island, Tennessee, Utah, Vermont, and Wyoming reported contracting with NPs as primary care providers. It is possible this list is larger. All participating MCOs in Alabama, Arizona, Connecticut, Illinois, Maryland, Minnesota, Montana, Oregon, South Dakota, and Washington, DC, also reported contracting with NPs. Each of these states, however, had nonrespondent MCOs, so the research team was unable to determine if MCOs in these states universally contracted with NPs. Figure 2 shows a geographic representation of MCOs' contracting practices with NPs.

Of the 159 MCOs that reported

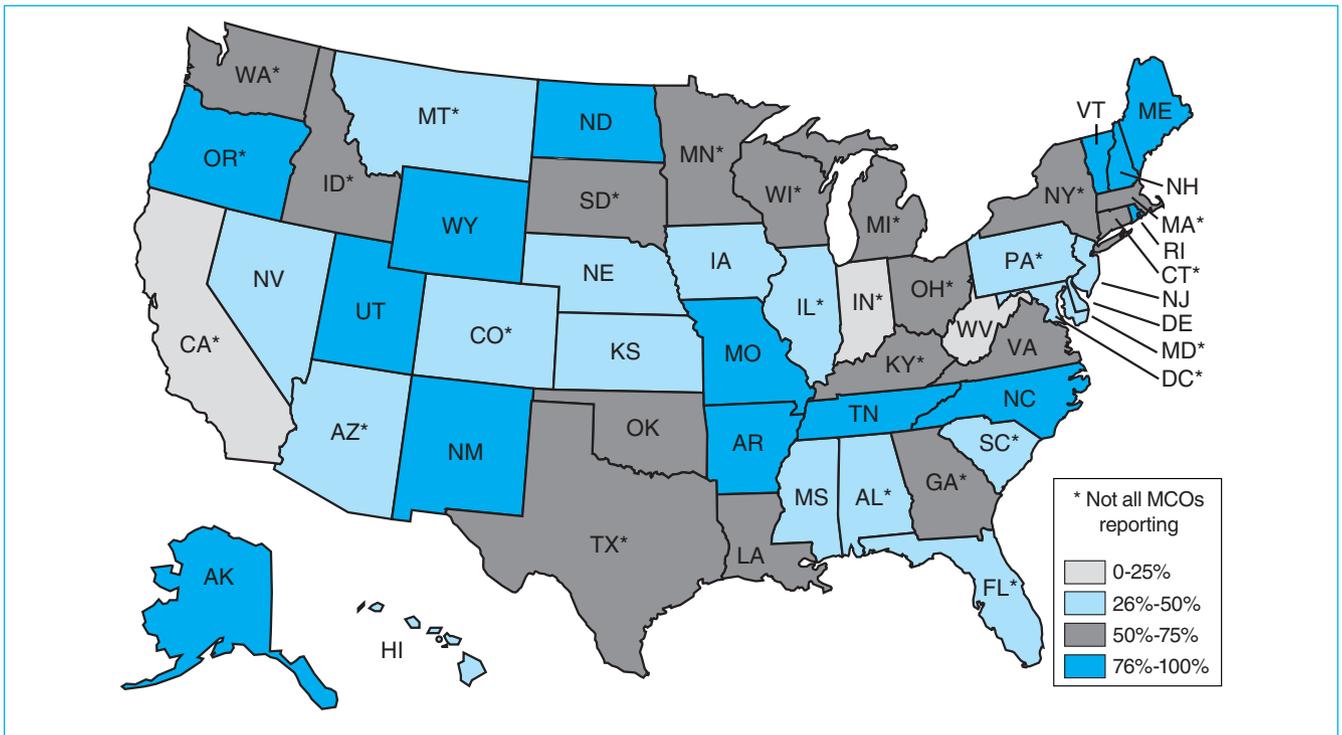
contracting with NPs, 34.6% ($n=55$) reported placing limits on nurse practitioners. Commonly noted restrictions were geographic borders on where NPs were able to practice (areas of provider shortage, underserved populations, and/or high need), whether or not the NP practiced in a federally qualified health clinic or practiced within a physician group (not independently), by insurance product line and requirement of supervision or a collaborative agreement with a physician. It should be noted that less than 1% ($n=5$) did not know or refused to answer regarding the MCO's restrictions on NPs.

Those MCOs who contracted with nurse practitioners varied in which products they allowed NPs to participate. Not all MCOs offered all products (Medicare, Medicaid, Exchange levels: catastrophic, bronze, silver, gold, platinum). For those that offered Medicare products ($n=146$), 66.4% ($n=97$) reported contracting with NPs to provide primary care services to beneficiaries ($n=11$ didn't answer or didn't know). For those that offered Medicaid products ($n=136$), 62.5% ($n=85$) reported contracting with NPs to provide primary care services to beneficiaries ($n=11$ refused to answer or didn't know). By inclusion criteria, all MCOs in this study were listed as offering insurance exchange products. Of those that contracted with NPs, 66% ($n=105$) contracted with NPs to provide primary care services to beneficiaries at the catastrophic level, 88.7% ($n=141$) at the bronze level, 90% ($n=143$) at the silver level, 90% ($n=143$) at the gold level, and 60% ($n=96$) at the platinum level.

Several MCOs stated they did not offer all levels of insurance (catastrophic through platinum) as options. Many MCOs also used alternative nomenclature to delineate levels of coverage. For a full breakdown of NP contracting by level of exchange product and additional exchange level information, see Figure 3.

Managed care organizations that contracted with NPs were also queried as to whether NPs

Figure 2.
Map of Managed Care Organizations Contracting with Nursing Practitioners, by Quartile Percentage



NOTE: This figure illustrates the quartile percentage of MCOs that report contracting with NPs by state.

were compensated at a rate equal to other primary care providers. In the past, this information has been viewed as sensitive and proprietary; thus, it was not a surprise some MCOs (11.3%; $n=18$) deferred or refused to answer this question. Overall, 22% ($n=35$) stated NPs were compensated at the same rate as other primary care providers, while 20.8% ($n=33$) stated they sometimes compensate NPs at the same rate. Conversely, 35.2% ($n=56$) reported compensating at a different rate than other primary care providers and 10.7% ($n=17$) stated they did not know this information.

Notably, of the MCOs contacted ($n=212$), 16% ($n=34$) reported contracting with NPs for services other than provision of primary care. Very few MCOs provided detail on the nature of services that would be included in these contracts. Those that did comment stated NPs were contracted to provide “case management” or “navigation consultation” services.

Of the 159 MCOs that contracted with NPs, 76.1% ($n=121$) stated nurse practitioners were listed in their provider directories. Ninety-three percent ($n=113$) of those NPs are listed as primary care providers, while 3.5% ($n=5$) of respondent MCOs listed NPs as “other” in their provider directories, and another 3.5% ($n=4$) did not know how NPs were classified.

Implications and Conclusions

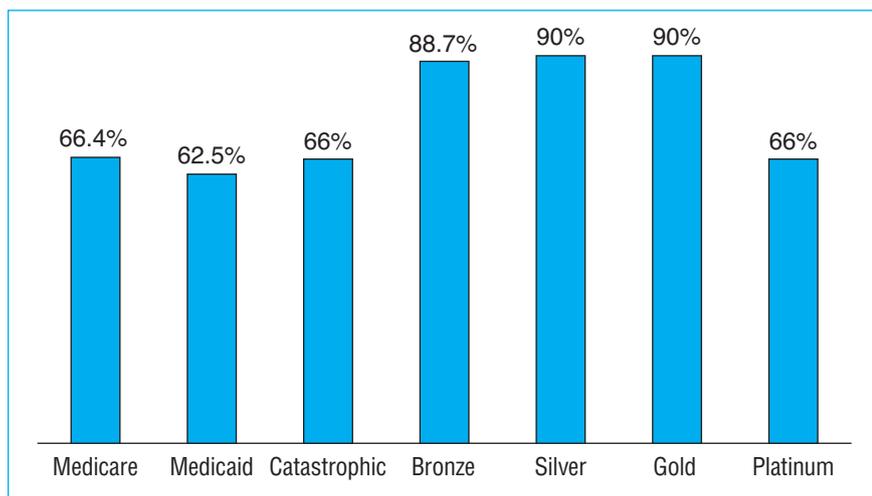
The results of this study are similar to the results of the research team’s 2011-2012 survey, which found 74% of the 258 MCOs surveyed credentialed NPs as primary care providers. In this most recent survey, 75% of 212 MCOs surveyed indicated contracting with NP primary care providers. From these results, it can be concluded about a quarter of MCOs still do not contract with NPs as primary care providers. This is important because it limits consumer access to health care, decreases provider choice, and

limits the cost and quality benefits of NP-delivered care.

Previous research found the percentage of MCOs credentialing NPs as primary care providers increased from 25% to 75% from 2005-2012. There are several possible reasons for this, two of which include the passage of the ACA and the release of the Institute of Medicine’s (2010) *Future of Nursing* report.

The framework of the ACA was built around the model used by the Commonwealth of Massachusetts when it passed its health reform legislation in 2006. Although Massachusetts achieved nearly universal insurance coverage, the Commonwealth did little to expand its primary care provider capacity. As a result, Massachusetts physicians had difficulty adjusting to the increased demand for care, which led to long delays. In 2009, the average wait time to see a physician in Boston was 46.9 days, the longest in the nation (Thompson, 2009). In an effort to

Figure 3.
Breakdown of NP-Contracting Managed Care Organizations by Level of Product (N=159)



NOTE: This figure illustrates the exchange product levels at which MCOs report contracting with NPs as primary care providers.

avoid the problems experienced in Massachusetts, the framers of the ACA included several mechanisms intended to boost provider capacity. Many of these, such as the creation of a grant program for NP-led health centers and funding for NP primary care residency programs, focused on encouraging greater use of NPs as primary care providers.

Similarly, the need for NPs to assume a greater role in primary care was a major theme of the IOM report. *The Future of Nursing* was released in October 2010, shortly after the ACA's enactment and contained the recommendation that nurses (NPs) should practice to the full extent of their education and training. It also highlighted the unwillingness of MCOs to contract with NP primary care providers as a barrier to the full development of the advance practice nursing role.

The results of the research team's 2011-2012 survey suggest that, after the passage of the ACA and release of the IOM report, many MCOs shifted their NP credentialing policies to accommodate the heightened demand for care that would accompany the implementation of healthcare reform. This most recent survey of NP contracting practices shows,

however, the trend toward greater utilization of NP primary care providers in managed care has not continued. Although the country is now 6 years into ACA implementation, the percentage of MCOs not utilizing NPs as primary care providers has remained steady at 25%. These policies seem particularly shortsighted and out of step with modern health care trends, especially when one considers demand for care continues to increase post ACA. The number of new Medicaid enrollees, for example, grew by a record 14% in FY 2015 (O'Donnell, 2015). Health Resources and Services Administration (HRSA) data shows NPs, not physicians, are better positioned to meet this demand. Of the 127,000 NPs providing patient care, over 60,000 are working in primary care (HRSA, 2014). HRSA predicts that, by 2020, there will be 72,100 NP primary care providers, which represents a 30% increase from 2010. By contrast, the number of primary care physicians is expected to increase by just 8% over the same period (HRSA, 2013).

Previous research from members of the research team examined reasons why an MCO chose

not to utilize NPs as primary care providers. The most popular reasons given included legal considerations connected to state-mandated physician supervision of NP practice, the belief NPs provide a limited scope of services, and company tradition (Hansen-Turton et al., 2008). Previous research suggests the presence of state laws requiring physician supervision of NP practice is one of the biggest factors influencing an MCO's decision whether or not to allow NPs to serve as primary care providers. In 2008, the research team found MCOs operating in states that permitted NPs to practice without any physician supervision were 20%-25% more likely to utilize NPs as primary care providers (Hansen-Turton et al., 2008). This conclusion continues to be supported in the current research, which found of the 13 states reporting all MCOs contract with NPs, 8 allowed NPs to practice without supervision.

As mentioned, the fact such a high percentage of MCOs are not contracting with NPs as primary care providers has negative implications for the ACA's goals of increasing access, lowering costs, and enhancing quality. There is currently a shortage of primary care physicians and demand for care continues to increase in the wake of ACA implementation. The American Association of Medical Colleges (AAMC) estimates that over 65,000 primary care physicians are needed to meet the projected demand for care over the next 10 years (AAMC, 2010). Nurse practitioners can assist in meeting the need for primary care providers, but restrictive MCO contracting policies limit the pool of available providers.

Further, the number of newly insured patients who have received coverage through the ACA's Medicaid expansion is about equal to the number of patients who have signed up for private insurance coverage through the exchanges. Approximately 84% of NPs see Medicaid patients and a large percentage practice in underserved

areas, (American Association of Nurse Practitioners [AANP], 2016), which places NPs in an ideal position to care for the rising number of new Medicaid patients. The research team, however, found only 62.5% of MCOs offering Medicaid products reported contracting with NP primary care providers (more than 10% lower than the overall average). This finding suggests that, along with restricting the ability of NPs to fill gaps in care for the general population brought on by the primary care physician shortage, the failure of MCOs to contract with NPs will place a disproportionate burden on low-income patients seeking to access care, especially considering Medicaid enrollment increased by a record 14% in FY 2015 (O'Donnell, 2015).

Nurse practitioners have also demonstrated the capacity to reduce costs. For instance, NPs practicing in Tennessee's state-managed MCOs delivered health care at 23% below the average cost associated with other primary care providers, achieving a 21% reduction in hospital inpatient rates and 24% lower laboratory utilization rates compared to other providers (AANP, 2013). Another study found MCO primary care practices that used more NPs in care delivery realized lower practitioner labor costs per visit than practices that used fewer NPs (Roblin, Howard, Becker, Adams, & Roberts, 2004). Finally, an analysis performed after healthcare reform legislation was enacted in Massachusetts determined the state could gain a cost savings of \$4.2-\$8.4 billion over a 10-year period from increased use of NPs (Eibner et al., 2009). Given the ACA is modeled after the Massachusetts legislation, it stands to reason the increased use of NPs nationally will produce a greater cost savings. MCO practices that exclude NPs prevent the full realization of these benefits.

The most significant way MCO contracting policies impact the quality of care is through the potential disruption of care continuity. It can take 6-8 months for an

NP to enroll in an MCO's primary care provider network and be approved to receive reimbursement. Nurse practitioners who begin seeing patients enrolled in the MCO during this 6-8 month waiting period may need to discontinue services if the MCO ultimately opts not to contract with them as a primary care provider. Additionally, the ACA includes incentives and penalties designed to encourage patients to enroll in a health insurance plan. Uninsured patients who had previously been receiving care at an NP-run safety-net clinic will need to switch providers if they select a plan administered by an MCO that does not contract with NPs. The switching of providers could cause a disruption in care that increases the likelihood patients will forego needed services.

Finally, NP-led safety-net clinics often operate on very limited budgets. The failure of local MCOs to contract with these providers limits the reimbursement available to the clinics, which in some cases has caused the clinics to close. Clinic patients are then forced to switch providers or seek care in hospital emergency departments, which dramatically raises the cost.

In 2012, the National Governors Association (NGA) conducted a comprehensive literature review looking at 30 years of research on NP quality of care. The NGA (2012) stated none of the studies they reviewed raised concerns about the quality of NP care. They went on to say that the "research suggests that NPs can perform many primary care services as well as physicians do..." (NGA, 2012, p. 1). MCO contracting policies that restrict access to NP primary care providers unnecessarily hinder the ability of patients to take advantage of the high-quality care NPs offer.

Geographic Implications

Findings from this study also have important geographic implications. The 10 states that have experienced the greatest reduction in uninsured individuals since

2013 are Arkansas, Kentucky, Delaware, Washington, Colorado, West Virginia, Oregon, California, New Mexico, and Connecticut (Sanger-Katz, 2014). Of these states, only Arkansas and New Mexico also reported all MCOs contract with NPs as primary care providers. It is possible Connecticut and Oregon could also be added to this list, but nonresponsive MCOs in those states prevented this determination. Conversely, West Virginia has experienced the 6th largest reduction in uninsured individuals since 2013 (Sanger-Katz, 2014), and yet none of its MCOs reported contracting with NP primary care providers.

The 10 states with the lowest number of active primary care physicians per 100,000 residents are Mississippi, Utah, Nevada, Idaho, Texas, Alabama, Oklahoma, Wyoming, Arkansas, and Georgia (AAMC, 2013). Of these, only Arkansas, with the possible addition of Alabama, also reported MCOs universally contract with NPs as primary care providers. Of the 10 states with the most active primary care physicians per 100,000 residents, three states (Maine, Rhode Island, and New Hampshire), with the possible addition of Maryland, report universally contracting with NPs as primary care providers (AAMC, 2013).

These findings suggest the decision whether or not to contract with NPs as primary care providers is a decision made by each individual MCO that is not influenced by the number of new patients obtaining coverage through the ACA, or the number of available physicians. This is especially true in the case of Nevada. Nevada was 12th among states experiencing the largest drop in uninsured residents since 2013 (Sanger-Katz, 2014). The state is also third among states with the least number of active primary care physicians per 100,000 residents (AAMC, 2013). Yet, the research team found two of the four MCOs surveyed in Nevada did not contract with NPs as primary care providers. Lastly, Massachusetts was the only New England state

MCOs reported not contracting with NPs as primary care providers. This indicates New England's MCOs have developed a particularly friendly attitude toward NP primary care providers that is not necessarily connected to the number of newly insured residents in those states, or the physician supply. More research is needed to determine the impact regional practice patterns are having on MCOs and NP contracting policies.

These findings are important for nurse leaders, educators, and advocates because they show that, despite the continued increase in the demand for care post ACA and the limited supply of primary care physicians, about a quarter of MCOs still have policies in place that prevent the utilization of nurse practitioners as primary care providers. The exclusion of such a large and growing segment of primary care providers presents challenges for healthcare policy-makers, individual nurses, and consumers. Restrictive MCO contracting practices have the potential to frustrate the ACA's efforts to expand access to care, lower costs, and enhance care quality. From a provider perspective, these policies limit the ability of NPs to reach the patients most in need of care and cause unnecessary disruptions in care continuity. The decision not to contract with NPs also precludes patients from being seen by the provider of their choice and experiencing the full benefit of nurse-led care. \$

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