DataWatch

Medicaid Payment For Nonphysician Practitioners: An Access Issue

by Catherine Hoffman

Abstract: As part of congressional efforts in the 1980s to expand access to care for Medicaid mothers and children, states were required to pay for services provided by certain advanced practice nurses. These mandates created the impetus in many states to expand payment policies for nonphysician practitioners. State Medicaid payment policies are often less restrictive than rhose of the Medicare program. However, not all states have been receptive to policy expansions and do not cover nonphysician practitioner services to the extent that professional practice acts allow. A few states have yet to meet the 1989 federal mandates.

All of the health care reform proposals before Congress recognize the heightened demand for primary care services and providers. Greater availability of primary and preventive care has been tied to cost savings and improved quality. To expand access to primary care providers, the Clinton administration's proposal specified means for increasing the number of primary care professionals, both physician and nonphysician practitioners. Nonphysician practitioners are cost-effective in terms of the costs of their educational preparation and perhaps also in their practice patterns and fees. How these professionals are paid and which of their services are covered have been contentious issues for more than two decades. This is evidenced by the patchwork of policies governing payment for their services, even within a single-payer system such as Medicare, and by substantial variation in payment rates among state Medicaid programs.

During the 1980s Congress mandated states to open provider enrollment to certified nurse-midwives and family and pediatric nurse practitioners, and to permit direct billing and payment for their services. Unlike physicians, who are concerned about Medicaid fee levels in comparison with other payers, nonphysician practitioners often found that Medicaid would not pay for their services at all. Although states have always had the option to pay for these services, federal mandates have led many states to evaluate payment policies for nonphysicians and their potential effect on access to

Catherine Hoffman is a research specialist with the University of California, San Francisco, Institute for Health and Aging. When this survey was conducted and analyzed, she was a senior analyst with the Physician Payment Review Commission in Washington.

primary and maternal care services.

Payment policies are not the only factors affecting access of Medicaid beneficiaries to the services of nonphysician practitioners. States also regulate their scope of practice, such as the amount of physician supervision required to practice and authority to prescribe medications. State Medicaid programs have purview only over payment policies, while professional licensing boards regulate all other areas. Recognizing that restrictive payment policies exist, the Health Security Act would have allowed for coverage of all professional services in the benefit package when furnished by those who are "legally authorized to provide such services in the state in which they are provided," overriding states' restrictions.[1]

To better understand the status of Medicaid payment for nonphysician services, the Physician Payment Review Commission (PPRC), working with the Intergovernmental Health Policy Project (IHPP), conducted a survey of state Medicaid programs on payment policies in late 1992. The survey was designed specifically to determine whether state Medicaid pay ment policies were enabling or restricting the participation of nonphysicians in primary and maternal care. The survey examined payment policies related only to those nonphysician practitioners most likely to provide these kinds of services: nurse practitioners, certified nurse-midwives, and physician assistants.[2] No other study has enabled comparisons among the different kinds of nonphysician practitioners within a state, as well as comparisons with current Medicare policy. Data from the PPRC/IHPP survey show considerable variation in payment policy, not only across states, but among the nonphysician disciplines within a state.

Survey results indicate that many states have responded to the federal Medicaid mandates by establishing nonrestrictive payment policies that enable certified nurse-midwives and nurse practitioners to participate fully in the program. Many states also have expanded their programs to include nonphysician practitioners other than those required by the mandates. Furthermore, state Medicaid payment policies are in many ways less restrictive than Medicare policies for nonphysicians. These changes may indicate both the need for participating practitioners and states' willingness to recruit nonphysician practitioners for primary and maternal care.

Not all states have been receptive to such policy expansions, however, as evidenced by policies that limit coverage or payment to certain nonphysician services or certain settings. Working within budget-neutral constraints in many cases, Medicaid programs are continually balancing two competing goals: improving access to care and containing the growth of Medicaid expenditures. As with Medicare, competing political coalitions also have shaped Medicaid payment policies. Nursing groups may be joined by legal aid groups, welfare advocacy groups, and even some physician groups in

claiming that payment for nonphysician services expands access to care cost-effectively. The opposing coalition often consists of insurance companies (concerned that state policy might increase pressure to change nonphysician payment in the private sector), state budget directors (concerned about rising Medicaid expenditures), and state medical societies (concerned about professional competition).

Federal Payment Policy For Nonphysician Practitioners

Medicare and federal Medicaid mandates for nonphysician practitioner coverage are often the template for state payment policies. In the late 1970s Medicare and Medicaid began to specify payment policies for nonphysician services. For the most part, both Medicare and federal Medicaid mandates have been instituted in response to perceived access problems for specific groups of beneficiaries. In addition, states have always had the discretion to expand coverage of such services beyond the federal Medicaid policies to meet each state's unique needs.

Since the beginning of Medicare and Medicaid in 1965, services performed by health professionals and allied health personnel employed in physician practices have been covered, with payment going to the employer. Known as the "incident to" provision, this policy allows payment of the full physician fee for office or clinic services provided by a physician's staff that are integral, although incidental, to the physician's services. The services must be provided under the direct (on-site) supervision of a physician and are paid for as if the physician had provided them. Because the "incident to" provision predates the development of most of the nonphysician practitioner programs, it does not address payment for physician assistants and advanced practice nurses employed in physicians' offices. Most state laws governing the scope of professional practice for physician assistants, nurse practitioners, and certified nurse-midwives do not require on-site supervision by physicians. Many nonphysician practitioners, however, practice in physicians' offices—roughly 20 percent of nurse practitioners and 38 percent of physician assistants.[3] Their services thus may be billed as physician services under the "incident to" provision.

When Medicare and federal Medicaid payment policies began to specifically distinguish nonphysician practitioners, they targeted beneficiaries in underserved rural areas. The Rural Health Clinic Services Act of 1977 made freestanding rural clinics staffed by nurse practitioners, physician assistants, or certified nurse-midwives eligible for Medicare and Medicaid payments. This was the first federal policy to separate nonphysician practitioner coverage from employment in a physician's practice.

Medicare and federal Medicaid policy changes that followed also speci-

fied particular nonphysician services without requiring on-site physician supervision (when allowed by state practice acts). These changes have not been enacted simultaneously for both Medicare and Medicaid, however, and are quite different for each program (Exhibit 1). Many of the statutes that followed the Rural Health Clinic Services Act continued to limit nonphysician practitioner coverage to rural areas. To address the unmet needs of beneficiaries in urban areas, the administration proposed to expand coverage of nonphysician services to such areas, amending Medicare statutes that limited coverage to rural areas.

Survey Methods And Findings

The PPRC/IHPP survey was conducted in fall 1992. State Medicaid officials were asked to respond to questions concerning payment for services provided by each nonphysician discipline, fee levels, and specific policies detailing service or practice setting restrictions. Questionnaires were mailed to the fifty state Medicaid program directors; forty-seven states responded. After the questionnaires were returned, all respondents were contacted by telephone to clarify responses and gather further information.

Medicaid payment policies for physician assistants. Physician assistants, by virtue of their practice acts, do not work independently from physicians and are not self-employed; Medicaid payment policies reflect this fact. Perhaps because of this–and because no federal Medicaid mandate (other than the Rural Health Clinic Services Act) requires states to cover physician assistant services–twenty-six states have not developed specific regulations for physician assistant coverage.

Like Medicare, nearly all state Medicaid programs make payment only to employers for the services physician assistants provide. Montana and South Dakota are the only states that give physician assistants the option to bill directly for their services. Physician assistants in these states use unique identification numbers when submitting Medicaid claims and receive a standard percentage of the physician's fee for each service.

While not allowing physician assistants to bill directly, nineteen states use some mechanism to identify physician assistant services on claims forms. In eleven of these states the mechanism makes no difference in the payment the employer receives; in eight states it triggers a reduced payment (often referred to as a differential payment rate) ranging from 50 percent to 90 percent of the physician fee (Exhibit 2). Some states apply the differen tial rate for particular services, such as those furnished in hospitals. Others apply the differential to those physician assistant services that are not provided as "incident to" the supervising physician's services.

Even though states may not have specific physician assistant payment

Exhibit 1
Federal Pavment Policies For Nonohvsician Practitioners

Service	Payment method	Statute applies to NP[a]	CNMb	PA[c]
Medicare Part B				
Rural health clinic services (1977)	Pays clinic reasonable cost, or included in all-inclusive fate for clinic services	●	●	●
Services to homebound patients in areas without home health agency (1977)	Pays employer at physician fee level	●		●
Services in managed care plans that have risk-sharing contracts with HCFA (TEFRA)[d]	Capitated payment to plan	●		●
Hospital and nursing facility services if such services would be covered if physician furnished (OBRA 1986)	Pays employer. Hospital services not to exceed 75 percent of physician fee; 65 percent for surgical assistance; nursing facility services not to exceed 85 percent of physician fee			●
CNM maternity cycle services only; no restrictions on site of service (OBRA 1987)	Pays CNM if self-employed; if not, pays employer; not to exceed 65 percent of physician fee		●	
Services provided in rural health nrofessional shortaee areas (OBRA 1987)	Pays employer 85 percent of physician fee			●
Services provided in nursing facilities (OBRA 1989)	Pays employer; amount not to exceed 85 percent of physician fee	●		
Services provided in rural settings (OBRA 1990)	Pays NP or clinical nurse specialist; hospital services not to exceed 75 percent of physician fee; all other services not to exceed 85 percent	●		
Federal Medicaid mandates				
Rural health clinic services (1977)	Pays clinic reasonable cost, or included in all-inclusive rate for clinic services	●	●	●
Services provided during maternity cycle (OBKA 1980)	Pays CNM or employer at rate set by state		●	
Services provided by certified pediatric and family NPs (OBR4 1989)	Pays NP or employer at payment rate set by state	●		

Source: PPRC compilation of federal legislation.
[a] Nurse practitioner.
[b] Certified nurse-midwife.
[c] Physician assistant.
[d] HCFA is Health Care Financing Administration; plans include health maintenance organizations and competitive medical plans. TEFRA is Tax Equity and Fiscal Responsibility Act.

policies, services of physician assistants are covered, of course, when provided as "incident to" physician services. In nineteen states in which the

Exhibit 2
Medicaid Payment Differentials For Nonphysician Practitioners, As Percentage Of Physician Fee. Bv State. 1992

State	PA	CNM	NP	State	PA	CNM	NP
Alabama	–[a]	80%	80%	Montana	80%	80%	80%
Alaska	–[a]	100	100	Nebraska	–[a]	100	100
Arizona[b]	100[c]	60	100	Nevada	–[d]	–[d]	–[d]
Arkansas	–[a]	80	80	New Hampshire	100	100	100
California	100	100	–[e]	New Jersey	–[a]	70	–[e]
Colorado	100	100	100	New Mexico	100	100	90
Connecticut	–[a]	90	90	New York	100	100	100
Delaware	–[a]	100	100	NorthCarolina	–[a]	100	100
Florida	–[a]	80	80	NorthDakota	50	75	75
Georgia	90	100	90	Ohio	85[f]	100	–[a]
Hawaii	–[a]	75	75	Oklahoma	–[a]	100	100
Idaho	–[d]	–[d]	–[d]	Oregon	100	100	100
Illinois	–[a]	70	–[e]	Pennsylvania	–[a]	100	100
Indiana	–[a]	75	75	Rhode Island	–[d]	–[d]	–[d]
Iowa	–[g]	80	80	South Carolina	–[a]	80[f]	80
Kansas	75	75	75	South Dakota	90	100	90
Kentucky	–[a]	75	75	Tennessee	–[h]	90	–[a]
Louisiana	–[a]	100	–[e]	Texas	–[a]	70	70
Maine	100	100	100	Utah	100	–[i]	–[a]
Maryland	100	–[i]	100	Vermont	–[a]	100	100
Massachusetts	–[a]	100	100	Virginia	–[a]	100	100
Michigan	–[a]	100	100	Washington	–[a]	100	100
Minnesota	90	100	–[k]	West Virginia	–[a]	100	100
Mississippi	–[a]	90	90	Wisconsin	80	80	100
Missouri	–[a]	100	100	Wvomine	100[b]	100	100

Source: PPRC/IHPP 1992 survey of Medicaid programs.
Note: PA is physician assistant; CNM is certified nurse-midwife; NP is family and pediatric nurse pracritioner.
[a] No specific state policy.
[b] Nonphysician practitioner payment methods are for the rare fee-for-service settings in Arizona's capitated Medicaid program.
[c] Modifier used only for assistants-at-surgery.
[d] No data available.
[e] Policy currently being developed.
[f] Differential limited to specific services.
[g] Differential varies depending on service: hospital, 75 percent; nursing facility, 85 percent; assistants-at-surgery, 65 percent.
[h] 60 percent for physician assistant hospital and nursing facility services; others 100 percent.
[i] Separate fee schedule for certified nurse-midwives.
[j] 70 percent for pre- and postnatal care; all other services 100 percent.
[k] Physician-employed nurse practitioners are paid 65 percent with modifier use required; all other nurse practitioners receive 90 percent.

"incident to" provision is strictly interpreted, Medicaid payment policy essentially requires on-site physician supervision of services.[4] In most of these states, however, the professional practice act does not require direct supervision. Rather, it allows physician assistants to work in off-site supervisory arrangements with physicians. Medicaid payment policy is more

restrictive than state physician assistant practice acts in sixteen states.[5]

Medicaid programs recognize that restricting coverage of physician assistant services to directly supervised settings limits the volume of services and patients that a physician/physician assistant team can manage. One state Medicaid official summarized the situation as one in which states may want to increase the number of participating practitioners, including nonphysicians, but cannot afford the costs associated with improved access.

Unlike Medicare statutes, Medicaid regulations do not restrict coverage of physician assistant services, or the services of any other nonphysician practitioners, to certain regions, such as rural areas or Health Professional Shortage Areas. This is because federal law requires that the amount, duration, and scope of Medicaid program benefits be the same statewide.

Medicaid payment policies for nurse practitioners. Of the forty-seven states responding to the survey, forty-one allow family and pediatric nurse practitioners to bill directly for their services (Exhibit 3). The federal mandate requires Medicaid programs to do so only in accordance with other state laws. In some states, complying with the intent of the direct payment mandate is complicated by the fact that nursing practice acts do not distinguish between nurse practitioners and other registered nurses (RNs). These states have had to either clarify their nursing practice acts or develop new Medicaid regulations. Because of this, six states still do not allow nurse practitioners to bill directly for their services; four of these states are developing regulations to meet the federal requirement.

States are required to pay only for family and pediatric nurse practitioner services, but more than half of the responding states also pay for services of other types of nurse practitioners. Seven states permit payment to obstetric/gynecologic or neonatal nurse practitioners in addition to family and pediatric nurse practitioners. An additional nineteen states allow all types of nurse practitioners to participate in Medicaid, making no distinction about what kind of nurse practitioner can receive payment. A few states also pay for services provided by clinical nurse specialists.[6]

When asked why a state allowed participation by other nurse practitioners in addition to family and pediatric nurse practitioners, state Medicaid staff cited concerns about an inadequate supply of participating physicians and the view that nurse practitioners were substitutes for physicians. States held that a variety of nurse practitioners could be enlisted, particularly those specializing in women's health, neonatal care, and school health services, since the purpose of the nurse practitioner provision in the Omnibus Budget Reconciliation Act (OBRA) of 1989 was to improve Medicaid access. In contrast, some of the states enrolling only family and pediatric nurse practitioners commented that even though nurse practitioners may prove to be cost-effective substitutes for physicians, the program could not

Exhibit 3
Direct Medicaid Payment For Advanced Practice Nurses, By State, 1992

State	F/P NP[a]	Other NP[b]	CNS[b]
Alabama	●	–[c]	
Alaska	●		
Arizona	●	●	
Arkansas	●	–[c]	
California	–[e]		
Colorado		●	
Connecticut	●		
Delaware	●	●	
Florida	●	●	
Georgia	●	–[c]	
Hawaii	●		
Idaho	–[d]		
Illinois	–[e]		
Indiana	●		
Iowa	●		
Kansas	●	●	●
Kentucky	●	●	●
Louisiana	–[c]		
Maine	●		
Maryland		●	
Massachusetts	●	●	
Michigan	●	●	
Minnesota	●	–[c]	
Mississippi	●	–[c]	
Missouri	●	–[c]	
Montana	●	●	
Nebraska	●		
Nevada	–[d]		
New Hampshire	●		
New Jersey	–[e]		–[e]
New Mexico	●	●	
New York	●	●	
North Carolina	●	●	
North Dakota	●	●	
Ohio			
Oklahoma	●	●	
Oregon	●	●	
Pennsylvania	●	●	
Rhode Island	–[b]		
South Carolina	●	●	
South Dakota	●	●	
Tennessee			
Texas	●		
Utah	●		
Vermont	●		
Virginia	●		
Washington	●	●	
West Virginia	●		
Wisconsin	●	●	–[f]
Wyoming	●	–[c]	

Source: PPRC/IHPP 1992 survey of Medicaid programs.
Note: F/P NP is family and pediatric nurse practitioner; CNS is clinical nurse specialist.
[a] Mandated.
[b] Optional.
[c] Coverage for only specific types of nurse practitioners.
[d] No data available.
[e] Regulations currently being developed.
[f] Wisconsin pays clinical nurse specialists for primary care services only.

afford to improve access by adding other practitioners.

Medicaid programs can vary the kinds of services they cover depending on the type of practitioner. States, therefore, have the option to pay for only some of the services practitioners are legally capable of providing (as determined by professional practice acts). Seven states specify particular Medicaid services that are not covered when performed by nurse practitioners. In most states, however, Medicaid pays nurse practitioners for all services covered in their plans, regardless of the setting, as long as the services are within the nurse practitioner's scope of practice.

Medicaid policies in a large majority of states either allow nurse practitioners to practice independently or require nurse practitioners to establish a

collaborative relationship with a physician.[7] However, nine states indicated that their Medicaid policy requires a supervised relationship between a nurse practitioner and a physician; seven of these states require off-site supervision. Either Medicaid policy was consistent with the nursing practice acts in these states, or the practice acts were silent on this point, leaving the state Medicaid program to determine the appropriate relationship with a physician. For the two states (Ohio and Tennessee) that do not allow nurse practitioners to bill directly, services are covered only when performed under the direct supervision of the billing physician, that is, as "incident to" the physician's services. Requiring on-site physician supervision of nonphysician practitioners affects access to basic primary care by limiting the number of Medicaid patients who can be seen and the number of sites where services can be offered.

Medicaid payment policies for certified nurse-midwives. All states are in compliance with the 1980 federal Medicaid mandate that allows certified nurse-midwives to bill directly for their services. Half of the responding states indicated that their programs pay for any services in their plans that also are within the scope of certified nurse-midwife practice. In these states, besides maternity care, family planning and routine gynecological services for nonpregnant women are paid for when performed by certified nurse-midwives. However, fifteen programs pay certified nurse-midwives only for services provided during the maternity cycle; another eight states limit Medicaid coverage to maternity and family planning services (Exhibit 4). Although maternity services constitute the bulk of nurse-midwifery practice, state Medicaid policies, like the federal Medicare policy, that do not cover services such as gynecological examinations create a payment barrier to regular preventive services for women. Furthermore, most certified nurse-midwives practice in settings where gynecological services can be provided; 67 percent practice in private offices, public clinics, birthing centers, or health maintenance organizations (HMOs). They are also more likely to practice in underserved areas than are obstetrician-gynecologists (OB-GYNs). Nineteen percent of all certified nurse-midwives work in high-poverty areas, compared with 10 percent of OB-GYNs.[8]

Medicaid policy concerning physician supervision requirements does not appear to be more restrictive than the nursing practice act for certified nurse-midwives in any state. As with nurse practitioners, most state Medicaid policies pay for certified nurse-midwives who practice in either collaborative or independent relationships with physicians. In seven states in which the nursing practice act specifically requires off-site supervision or is silent regarding the amount of physician supervision, Medicaid payment policy requires off-site supervision as a condition of payment. No state requires on-site supervision of certified nurse-midwives.

Exhibit 4
Coverage Of Medicaid Services By Certified Nurse-Midwives, By State, 1992

State	All services covered	Maternity/ family planning services	Maternity services Only	State	All services covered	Maternity/ family planning services	Maternity services only
Alabama		●		Montana	●		
Alaska		●		Nebraska	●		
Arizona	●			Nevada	–[a]		
Arkansas			●	New Hampshire	●		
California	●			New Jersey			●
Colorado	–[b]			New Mexico		●	
Connecticut		●		New York			●
Delaware	●			North Carolina	●		
Florida	●			North Dakota			●
Georgia	●			Ohio	●		
Hawaii	–[a]			Oklahoma			●
Idaho	–[a]			Oregon	●		
Illinois		●		Pennsylvania		●	
Indiana			●	Rhode Island	–[a]		
Iowa			●	South Carolina	●		
Kansas	●			South Dakota	●		
Kentucky	●			Tennessee			●
Louisiana			●[c]	Texas			●
Maine	●			Utah		●	
Maryland	●			Vermont			●
Massachusetts			●	Virginia			●
Michigan	●			Washington	●		
Minnesota	●			West Virginia			●[c]
Mississippi	●			Wisconsin		●	
Missouri			●	Wvomine	●		

Source: PPRC/IHPP 1992 survey of Medicaid programs.
[a] No data available.
[b] All services except assistants-at-surgery, mental health, and outreach services.
[c] State will also pay for services related to the use of Norplant contraception.

Payment levels for nurse practitioners and certified nurse-midwives. Fee levels for nonphysician practitioner services have been negotiated as each of the state regulations were introduced. Several factors contribute to the final decision, including the program's budget for practitioner services, when the regulation was introduced, the precedent set by federal policies, and the activity of local health care lobbies. Interestingly, many state Medicaid programs, unlike Medicare, pay nurse practitioners and certified nurse-midwives at the same fee level as physicians. These states may be compensating for the fact that their Medicaid physician fee levels are considerably lower than Medicare fees already and perhaps are concerned that an even lower fee might adversely affect nonphysician

practitioner participation. In twenty-six states certified nurse-midwife services are paid at 100 percent of the physician fee level; in twenty-two states nurse practitioners are paid at 100 percent.

To determine if there is any relationship between nonphysician practitioner payment levels and physician fees, the state policy of paying nonphysician practitioners either the full physician fee level or a differential rate was compared with its Medicaid-to-Medicare physician fee ratio.[9] Physician fees and nurse practitioner payment levels were significantly correlated ($r = -0.36$, $p = .02$). States with below-average Medicaid-to-Medicare physician fee ratios are more likely to pay nurse practitioners 100 percent of the physician fee level. Among states with above-average physician fee ratios, nurse practitioners are less likely to be paid the same fee as physicians. The study found no correlation between certified nurse-midwife payment levels and physician fee levels, however.

In states in which advanced practice nurses are paid less than physicians, the differential varies considerably, ranging from 65 percent to 90 percent of the physician level. Only twelve states have set a nurse practitioner payment rate of less than 85 percent, the Medicare payment level for nonhospital services. The most common differential rate for certified nurse-midwives is 80 percent of the physician level. No state pays certified nurse-midwives less than Medicare's rate of 65 percent (Exhibit 2).[10]

Payment differentials are viewed as a means to reduce costs. However, differential payments for services provided by nonphysician practitioners working in physician practices are not made unless the services are billed directly or the claim form identifies who provided the service. Medicaid staff in several states pointed out that changes in Medicaid payment policy for nurse practitioners have not resulted in significant changes in practice arrangements. Given that Medicare and private payers do not consistently cover nonphysician practitioner services, many of these practitioners are likely to continue working as employees in physicians' offices. Because nurse practitioners and certified nurse-midwives have the option to bill Medicaid directly or through their employer, there is a financial incentive to bill for services provided in physicians' offices and clinics as "incident to" the physician's care, thereby guaranteeing full physician payment for the service. Any potential cost savings anticipated by setting a differential payment structure for nonphysician practitioners is diminished, unless the state requires such practitioners always to use their own claims identifier.

Summary And Policy Implications

The results of this survey suggest that many Medicaid programs have considered the advantages of using nonphysician practitioners for primary

and maternal care services and have established payment policies to encourage access to nonphysician practitioners. In summary, state Medicaid programs have significantly expanded service coverage and payment for nonphysicians in the following ways: (1) State Medicaid policies, unlike those of Medicare, cannot limit coverage to rural settings. Nonphysician services are covered in all regions of a state. (2) More than half of the states that pay nurse practitioners and certified nurse-midwives directly do so at the full physician fee level. All states pay certified nurse-midwives a percentage rate that exceeds Medicare's level; two-thirds of the states pay nurse practitioners more than 85 percent of the physician fee. (3) Although Medicaid mandates require only family and pediatric nurse practitioner coverage, more than half of the states have allowed other types of nurse practitioners to participate as well,

While these policies demonstrate efforts to expand nonphysician practitioner participation, other state policies potentially impede their participation. First, several Medicaid programs do not cover physician assistant services to the extent that their practice acts would allow. Second, some states do not pay advanced practice nurses for all of the Medicaid-covered services they are licensed to provide. Third, a few states have yet to meet the 1989 federal Medicaid requirement of payment for family and pediatric nurse practitioners, primarily because nurse practitioners are not clearly distinguished from other RNs in the state's nursing practice law. Finally, while payment policies were the focus of this survey, they represent only some of the barriers restricting use of nonphysician practitioners. Any policy designed to improve access to nonphysician services also must address the scope of professional practice authorized in state practice acts.

The *views expressed here are those of the author, and no endorsement by the Physician Payment Review Commission (PPRC) is intended or should be inferred. The author hanks Connie Wessner and Richard Merritt of the Intergovernmental Health Policy Project at The George Washington University for their tenacious survey efforts. Personal thanks go also to PPRC colleagues David Colby, Lauren LeRoy , and Sally Trude for their advice at various stages of this project.*

NOTES

1. Health Security Act, Title I, Subtitle B, Sec. 1161.
2. Educational preparation varies for the roles of nurse practitioner, certified nurse-midwife, and physician assistant. Building on baccalaureate degrees in nursing and licensure as a registered nurse, nurse practitioners and certified nurse-midwives typically are trained in graduate-level programs lasting eighteen to twenty-four months. Other advanced nurse training programs may offer certificates beyond the baccalaureate or master's level. Nurse practitioners and certified nurse-midwives are prepared to practice independently from physicians, but with collaborating relationships established for appropriate transfer when patients' needs require medical skills and interventions

beyond the scope of nursing practice. The collaborating physician is not legally responsible for the advanced practice nurse's care.

Variation in how state boards of nursing recognize advanced practice nurses is great, ranging from no recognition to certification to a second licensure. The distinction between licensure and certification is significant. Licensure defines legal practice and gives a person a property right to practice his/her profession, and if a regulatory agency wants to revoke a license, the person has a right to a public hearing. In contrast, certification is a moderate form of regulation, granting recognition to persons who meet certain qualifications established by a state agency, often guided by the profession's standards. The title can be used only by those who meet the qualifications; however, other noncertified persons may perform the same types of services but may not call themselves by the certified title.

Physician assistants' training typically consists of a twenty-four-month program, which is affiliated with a medical teaching center. A bachelor's degree is not a prerequisite to the training, although most physician assistants have a bachelor's degree. Certification is required for practice in forty-two states and is obtained by passing the National Commission Certification of Physician Assistants examination and by having graduated from an American Medical Association-approved program. Physician assistants are registered by states and typically need to identify either their employer or their supervising physician as part of the registration. Physician assistants are prepared to practice under the supervision of physicians (who do not need to be present at the site of care but who are legally responsible for the physician assistant's care)-a more directly accountable relationship to physicians than that of advanced practice nurses. The role was never intended to be one of independent practice.

3. Physician Payment Review Commission, *Annual Report to Congress,* 1994 (Washing ton: PPRC, 1994), 268-269, chap. 14, Tables 14-1 and 14-2.
4. Although a state may require on-site supervision in all other settings, physician assistants in rural health clinics or federally qualified health centers are not required to be directly supervised, according to federal Medicaid mandate,
5. Medicaid payment policy for physician assistant services is more restrictive than the state's physician assistant practice act in Alaska, Arkansas, Colorado, Connecticut, Florida, Hawaii, Kentucky, Louisiana, Massachusetts, Minnesota, Oklahoma, Pennsylvania, Tennessee, Texas, Vermont, and Virginia.
6. Clinical nurse specialists are registered nurses prepared with master's degrees in a specific clinical field of nursing.
7. A collaborative arrangement is one in which the physician is not legally responsible for the nurse practitioner's practice. Instead, the two practitioners establish a referral mechanism so that a patient's care can be appropriately transferred to the physician when needed. Sometimes the practice act may stipulate that the nurse practitioner and physician establish protocols or guidelines for management of common problems and describe appropriate referral situations.
8. PPRC, *Annual Report to Congress,* 1994, 270, chap. 14, Tables 14-3 and 14-7.
9. The Urban Institute estimates of the ratio between 1990 Medicaid fees and 1992 Medicare fee schedule levels were used. P. Loprest and M. Gates, *Health Care Financing Reform: A State Data Resource* (Washington: The Urban Institute, 1992).
10. The only exception is Arizona, where certified nurse-midwives are paid 60 percent of the physician fee level when they provide services in a fee-for-service setting. However, services are rarely paid in this manner because nearly all of Arizona's beneficiaries are enrolled in managed care systems with capitated payments.