Appendix B

Payment for the Services of Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives

Health-care services are paid for by individuals and by third-party payers. Third-party payers in the private sector include commercial insurance companies; hospital and medical plans, such as Blue Cross and Blue Shield; prepaid group medical plans, such as health maintenance organizations (HMOs); and others, such as labor unions or employers of insured individuals (106). Specific benefits, exclusions, and limitations on financial coverage vary from one third-party payer to another and differ even among the policies and plans offered by a particular payer. However, State and, to a lesser extent, Federal laws and regulations require private third-party payers to offer some benefits and do not permit them to offer others.

The Federal Government plays a significant role in paying for health-care services under four primary-health-care programs. The government acts as a third-party payer for health care under the Medicare and the Medicaid programs. Although the Health Care Financing Administration (HCFA) is the Federal agency responsible for both Medicare and Medicaid, the two programs differ considerably in their payment practices and covered populations. Medicare is a nationwide health insurance program for the *27.5* million Americans who are at least **65** years of age and for **2.9** million disabled Americans, Part A, the Hospital Insurance Program helps pay for hospital services, related institutional services, and other services. Part B, the Supplementary Medical Insurance Program covers physicians' services and many other medical services. Medicaid is a joint Federal-State program for **22** million low-income persons. The program is administered by individual States under general Federal guidelines, which include mandatory minimum benefits that all States must provide to eligible recipients and optional benefits that individual States may elect to provide to recipients.

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the third medical-benefits program provided by the Federal Government, is administered by the Department of Defense (DOD) (245), CHAMPUS covers nearly 8 million dependents of military personnel, retirees, and dependents of retirees inside and outside the United States (60).

The fourth medical-benefits program provided by the Federal Government is the Federal Employees Health Benefits Program (FEHBP), a voluntary health-care program that provides health insurance for approximately 10 million Federal employees and their dependents. Enrollees receive health-insurance services from more than 300 health-benefit plans under *con*tracts negotiated with the Office of Personnel Management of the U.S. Government **(256).**

As table B-1 shows, payment for the services of nurse practitioners (NPs), physician assistants (PAs), and certified nurse-midwives (CNMs) varies considerably, in part because of variations in the State laws and regulations that govern these providers' practices and payment. Table B-1 provides a generalized overview of the payment practices of the major third-party payers in the public and private sectors. These practices are described in greater detail below.

Nurse Practitioners and Physician Assistants

Government-Sponsored Programs

Medicare.—Under Part B of the Medicare program, coverage and payment for NPs' and PAs' services are restricted to services not traditionally performed by physicians, to services normally delegated by physicians, and to services performed under the direct supervision of physicians. This provision is commonly termed the "incident to" provisional

> Under this provision, services of nonphysicians may be covered where they are of types which are commonly performed by physicians' office personnel, and are performed by employees of the physician under his or her direct supervision, e.g., giving injections, taking temperatures and blood pressures, performing blood tests, etc. Payment cannot be made, however, for services performed by nonphysicians where the services are of

'The relevant Medicare Part B regulation prohibits payment for medical services rendered by someone other than a physician except for services that are "furnished as an incident to a physician's professional services of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in physician's bills. " Sec. 1861(s)(2)(A) of the Social Security Act, 42 U, S.C. Sec. 1395(s)(2)(A), 20 CFR 405-231(b).

Table B-1 .—Coverage and Direct Payment for Services[a] of Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives

	Nurse practitioners		Physician assistants		Certified nurse-midwives	
Third-party payer	Coverage	Direct payment	Coverage	Direct payment	Coverage	Direct payment
Medicare:						
Part A	No	No	No	No	No	No
Part B	No	No	Nob	No	No	No
HMOs[c]	Yes	NA	Yes	NA	Yes	NA
State Medicaid programs[d]	Some programs	A few programs	Some programs	None	Almost all programs	Almost all programs
Medicare and Medicaid:						
Rural Health Clinics	Yes	No	Yes	No	Yes	No
CHAMPUS[e]	Yes	Yes	No	No	Yes	Yes
FEHBP[f]	7 plans	7 plans	6 plans	6 plans	20 plans	20 plans
Private insurance	In some States	In some States	No	No	In some States	In some States

NA = not available
[a]Services that are typically and characteristically provided by Physicians.
[b]During the publication of this case study, the Omnibus Reconciliation Act of 1986 (Public Law 99.509) was enacted The act modifies part B Of Medicare and authorizes payment for (covers) services of physician assistants working under the supervision of physicians in hospitals, skilled nursing facilities, intermediate-care facilities, and as an assistant at surgery. The payment is indirect and at levels lower than physicians would receive for providing comparable services
[c]Health maintenance organizations.
[d]State Medicaid programs have the option of including NP and PA services in their State Medicaid Plans. *Congress* mandated coverage of CNMs' services in 1980 As of January 1985, all States in which CNMs practiced either were complying with the law (Public Law 96-499) or were considering changes in their Medical plans to comply with the law.
[e]Civilian Health and Medical Program of the Uniformed Services
[f]Federal Employees Health Benefit Program. FEHBP has 21 fee-for-service plans, some of which authorize PaYment to *NPs* PAs, and CNM *S*
[g]Whether State laws and regulations require or permit insurance *coverage* and direct payment for the services of NPs, PAs, and CNMs

SOURCE Office of Technology Assessment, 1986

the kinds which are typically and characteristically rendered by physicians, e.g., prescribing medications, setting casts on fractures, assisting at surgery, and other activities that involve an independent evaluation or treatment of the patient's condition even if the attending physician is directly supervising these services (64).

The "incident to" provision was partly intended to reduce the possibility of physicians' making excessive profits by employing large numbers of assistants **(162).** The provision has been refined over time, and its complexity has led to varied interpretation by physicians. Strictly interpreted, the provision means that Medicare only pays for physicians' typical services when they are actually provided by physicians. Knowingly or unknowingly, however, some physicians bill for services irrespective of who performs the service. Unless audits are performed, Medicare contractors have difficulty determining who has rendered services from the Medicare billing form. One of the "incident to" provision's effects has been to sharply limit the administratively independent practice of NPs who cannot bill Medicare for medical services.

This provision was modified in **1980 (248)** to permit generally supervised nurses and other paramedical personnel—such as NPs and PAs—to provide certain services to the homebound in some medically underserved areas. The "incident to" provision is waived only in areas that do not have certified home-health agencies. In 1984, there were **5,247** Medicare certified home-health agencies (164), and the number is growing (115). Presumably, therefore, NPs and PAs provide services to homebound patients only to a limited extent and only in areas where home-health agencies do not find it economical to function.

The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) allows for Medicare coverage of NPs' and PAs' services in HMOs and competitive medical plans (CMPs) that have entered into certain contractual risk-sharing arrangements with HCFA.[2] The implementing regulations permit NPs and PAs in HMOs and CMPs to furnish services without the direct personal supervision of physicians.[3] The NPs and PAs essentially can provide whatever services State law authorizes, including supervising or ordering services and supplies incidental to the services.

During the publication of this case study, the Omnibus Reconciliation Act of 1986 (Public Law 99-509)

[2]Calculations of cavitation rates do not include NPs' or PAs' salaries but are determined by the average adjusted per capita costs which are based on the costs of past services received by beneficiaries who fall into particular sets governed by such factors as geographic location, age, sex, and eligibility.
[3]*Federal Register, vol. 50, No. 7,* Thursday Jan. 10, 1985, p. 1351.

was enacted. The act modifies Medicare and authorizes payment for (covers) services of PAs working under the supervision of physicians in hospitals, skilled nursing facilities, intermediate-care facilities, and as an assistant at surgery. The payment is indirect and at levels lower than physicians would receive for providing comparable services.

Medicare's payment for inpatient hospital services under Part A does not specify coverage or payment for NPs' and PAs' services, either under Medicare's former cost-based reimbursement method or the current prospective-payment system. Hospitals usually pay for NPs' and PAs' services by salaries; the salaries and other costs of employing or contracting with NPs and PAs are included in the hospitals' formulas for calculating operating costs. Under cost-based reimbursement, Medicare pays the hospital the total operating costs associated with Medicare beneficiaries. Under the prospective-payment system, Medicare pays a fixed amount for each patient admitted; the aggregated amount is intended to cover the hospitals' total operating costs for Medicare beneficiaries.

Medicaid.—Under Medicaid, each State has considerable discretion to design its program within broad Federal guidelines. Covering and paying for the services provided by NPs and PAs is one of the benefits a State may choose to include in its Medicaid Plan. Data on the number of State Medicaid programs that cover NPs' services are not collected by HCFA's central office. Although the available data conflict, they indicate that State Medicaid programs are cautious about extending payment to NPs. A 1985 study noted that NPs were authorized to receive direct payment or indirect payment—i.e., to bill directly or through physicians—in 21 State Medicaid programs (60). An earlier study found that of the 26 State Medicaid programs that covered NPs' services, most paid indirectly. Nineteen of the twenty-six States adopted the Medicare approach of allowing payment only for NPs' services that were incidental to physicians' services (22).

A preliminary survey of State Medicaid programs found that 26 of the 36 State Medicaid programs covered PAs' services (5). Of those 26 programs, 18 reimbursed for PAs' services at the same rates as physicians', 4 reimbursed at lower rates, 2 reimbursed on a cost basis, and the remainder did not respond to the question. Most of the State Medicaid programs' requirements for supervision by physicians were similar to the requirements contained in State laws governing PAs' practice. (In most States, the scope of PAs' practice is controlled under medical-practice acts and regulations.) Other State Medicaid programs require that physicians review patients' charts every 7 days, that physicians be onsite, or that physicians be present. The scope of services covered for PAs also varied from the general (e.g., all the services cited in the PA law governing scope of services) to the specific (e.g., examinations under the program Early and Periodic Screening, Diagnosis, and Treatment; services in community health centers; and services in family planning agencies). Three States specified that only "incident to" services (i.e., services not traditionally performed by physicians) were covered for payment *(25).*

Medicaid payment for inpatient hospital services differs by State. Although 41 State Medicaid programs paid for hospital inpatient services on a retrospective cost basis at the beginning of 1980, 34 State Medicaid programs had some form of prospective-payment system as of December 1985 (133). Each State Medicaid program pays for operating costs—including salaries and other costs associated with NPs and PAs—according to its unique payment method for inpatient services (40).

Rural Health Clinics.—Access to primary-care services by NPs and PAs in satellite settings in isolated areas was hindered by the fact that payment for such services was available under Medicare and Medicaid only if a physician was on the premises when the services were delivered. The Rural Health Clinic Services Act of 1977 (Public Law 95-210) waived such restrictions for NPs and PAs practicing in certified rural health clinics located in designated underserved areas. The act permits payment for the services of NPs and PAs even when they are not directly supervised by physicians at all times. This allows rural clinics staffed only by NPs and PAs backed up by physicians to provide reimbursable primary care typically provided by physicians, so long as written plans of treatment are periodically reviewed and approved by physicians. Payment, which is based on reasonable costs, is made to the employing clinic, not to the NP or PA, and is restricted to services that State legislation authorizes NPs and PAs to perform.

Nursing Homes.—Various Medicare and Medicaid regulations, in addition to coverage and payment provisions, limit the provision of certain services by PAs and NPs in nursing homes. In some States, the laws permit physicians to delegate such services to NPs and PAs.

Only physicians can provide certain services if a facility is to:

1. be certified as a skilled nursing facility (SNF) in the Medicare and Medicaid programs (42 CFR 405.1123,1124,1125,1126, and 1128);
2. be certified as an intermediate-care facility (ICF) in the Medicaid program (42 CFR 311, 334, 343, and 346);
3. obtain certification and recertification of a patient's need for care in an SNF in the Medicare program *(42* CFR 456.260, 270, and 280); or

4. obtain certification of a patient's need for care in an SNF and ICF in the Medicaid program (42 CFR 456.360, and 380).

The specific services that must be performed by physicians vary according to the type of certification and the program. Under the Medicare and Medicaid programs, for example, patients can be admitted to SNFs based only on physicians' medical findings, diagnosis, and orders. Patients' care must be supervised by physicians, and patients must be seen by physicians at least every 30 days for the first 90 days after admission. Only physicians can prescribe drugs and order diagnostic and specialized rehabilitative services and therapeutic diets.

Unlike Medicare, Medicaid allows NPs and PAs to recertify patients' needs for institutional care. NPs and PAs are authorized to recertify the necessity of continuing medical care in SNFs (42 CFR 456.260) and ICFs (42 CFR 456.360) where general supervision is provided by physicians.

Civilian Health and Medical Program of the Uniformed Services. -The Federal Government, through the Department of Defense's CHAMPUS, has taken the lead in treating NPs as autonomous and independent providers of care for payment purposes. CHAMPUS began billing and paying for NPs' services on an experimental basis in fiscal year 1980. When the experiment ended 2 years later, CHAMPUS continued coverage and direct fee-for-service payment of NPs, thereby recognizing them as a distinct group of providers deserving direct compensation for services (60). Although CHAMPUS does not cover PAs' services, PAs are not seeking coverage under CHAMPUS, because DOD has indicated that CHAMPUS will begin contracting out its services and cease paying on a fee-for-service basis (83).

Federal Employees Health Benefit Program.—Like CHAMPUS, FEHBP experimented with direct payment and required that all FEHBP plans directly pay health practitioners, including NPs and PAs, who were licensed under applicable State law in those States where at least **25** percent of the population was located in formally designated primary-medical-care manpower -shortage areas (60). After the experimental period of January 1980 to December 1984, FEHBP did not require plans to compensate NPs and PAs directly.

Payment to providers of covered services currently depends on the terms of the FEHBP's contract with each health-benefit plan and thus varies among the plans. There is no statutory requirement that all plans offer payment to NPs and PAs, but some plans currently authorize NPs and PAs to receive direct payment or reimbursement for covered services without referral or supervision (see table B-1). Of the 21 fee-for-service plans participating in FEHBP for the contract year 1986, 7 cover and offer direct payment for services of NPs and 6 cover and offer direct payment for the services of PAs[4](256). Only 14 percent of enrollees in FEHBP are enrolled in plans that cover NPs' services and 11 percent of enrollees in FEHBP are enrolled in plans that that cover PAs' services. Direct payment for NPs and other providers is now under consideration by Congress.[5]

Private Insurance

Private third-party payment for NPs' and PAs' services is subject to State laws and health insurance regulations. Increasing numbers of States have passed laws and regulations concerning payment for the services of NPs and PAs. Such laws and regulations must accord with the States' requirements governing the scope of practice of these providers and, in some cases, of physicians.

The State payment laws vary in a number of dimensions, including the types of insurers affected (for-profit, nonprofit, or both) and the types of insurance policy (22). Some laws affect the services of all nurses; others affect only special groups of nurses, such as NPs. Some States require insurers to include nurses' services as a reimbursable benefit (mandatory benefit), whereas other States require insurers to offer reimbursement for nurses' services as an option in their policies (mandatory option) (232).

[4]The numbers do not include the more than 300 prepaid comprehensive medical plans in the FEHBP, because the organization of medical delivery systems under these plans makes the issues of direct access, payment, supervision, and referral largely irrelevant.

[5]In early 1986, President Reagan vetoed H. R. 3384 which contained a provision requiring direct reimbursements to nurses and nurse-midwives who provide services to employees covered by the FEHBP. Congress then passed new legislation, Public Law 99-251, directing the Office of Personnel Management (OPM) to study and report to Congress on the advisability of amending the law governing FEHBP to provide mandatory recognition of additional health-care practitioners, such as nurse-midwives, nurse practitioners, chiropractors, and clinical social workers. The legislation extended direct reimbursement for nonphysician providers in medically underserved areas, which are determined by the Department of Health and Human Services to have at least 25 percent of the population living in areas with inadequate numbers of medical providers. OPM's study advised against mandatory coverage on grounds specific to FEHBP (e.g., mandating coverage would not increase the choice of practitioners available to plan members, nor would it necessarily increase competition among the plans). Nonetheless, the Subcommittee on Compensation and Employee Benefits of the House Committee on Post Office and Civil Service remains interested in the topic. The subcommittee held hearings on direct reimbursement for nonphysicians on Apr. 15, 1986, and indicated its intention to continue studying the issue. H.R. 4825, introduced on May 14, 1986, would authorize direct payment for services performed by NPs and CNMs and other health-care providers. As of June 1986, the bill had been reported favorably by the House Committee on Post Office and Civil Service and was awaiting floor action. The bill did not pass the 99th Congress.

Although direct third-party payment is the exception rather than the rule, 13 States currently permit direct payment for NPs' services (24). The wide variation in conditions for payment of NPs' services is apparent in the laws of Mississippi, Maryland, and Oregon regarding supervision by physicians. In all three States, insurers must pay for any service that is within NPs' lawful scope of practice, but Mississippi requires the NPs to work under the supervision of physicians, whereas Maryland prohibits direct payment to NPs who work under the direct supervision of physicians (101). In Oregon, supervision by physicians is not a condition for reimbursement **(2 I).**

No State laws mandate coverage of PAs' services. Except in Wisconsin, State laws are silent even about optional coverage of PAs' services **(83).** None of the States mandate direct reimbursement for PAs' services; indeed, 16 States explicitly prohibit it. Although there is anecdotal information concerning third-party payers who cover PAs' services, sometimes under physicians' billing, information concerning the extent of coverage is not available.

Businesses in the United States are beginning to provide insurance that pays directly for NPs and PAs (as well as CNMs). The Washington Business Group on Health recently conducted a national survey of its member organizations, all of which are large firms. Of the approximately 200 respondents, 43 percent are paying directly for the services of NPs, and 39 percent are doing so for PAs (91). The proportion of member companies reimbursing NPs and PAs (and CNMs) has increased steadily over the past decade (91).

In many States, NPs' and PAs' services still must be "incident to" physicians' services, for payment purposes, and compensation for NPs' and PAs' services must be made to their employing physicians or organizations. Nevertheless, the recent changes in some States' laws and in the policies of major corporations suggest a movement away from requirements for direct supervision by physicians. Increasingly, NPs and PAs can function administratively independently of physicians and qualify for direct payment. Also, more States are likely to pass legislation providing for the direct compensation of NPs and PAs.

Certified Nurse-Midwives

Government-Sponsored Programs

Medicare and Medicaid.—Medicare's policies concerning payment are the same for the services of CNMs as for the services of NPs and PAs. Medicaid's payment policies are much more permissive for CNMs' services than for NPs' and PAs' services. In 1980, Congress enacted legislation (Public Law **96-499)** to require that CNMs' services be a mandatory benefit under Medicaid. The Federal statute recognizes CNMs' autonomous practice expressly stating that the mandated benefit shall be provided "whether or not he is under the supervision of, or associated with, a physician or other health care provider" (60). HCFA issued the regulations that implemented this law in May 1982. As of January 1985, all States in which CNMs practiced either were complying with the statute and the regulations or were considering changing their Medicaid plans to bring them into compliance. Currently only four States and the District of Columbia do not provide for direct Medicaid payment to CNMs, and HCFA's regional offices are working with these jurisdictions to bring them into compliance **(235).** Furthermore, the Medicaid statute was amended by Public Law **98-369** to ensure that birthing centers operated by CNMs need not be administered by physicians to be eligible for coverage as Medicaid clinic services.

Rural Health Clinics.--CNMs are treated differently from NPs and PAs under the Rural Health Clinics Act. Only rural clinics employing NPs or PAs are eligible for certification under the act (Title **42,** Section 481.4). Once a clinic is certified, however, it can receive payment for the services of the CNMs it employs.

Civilian Health and Medical Program of the Uniformed Services.—CHAMPUS singled out CNMs for special consideration before it experimented with direct payment for NPs' services starting in 1980. The Defense Appropriations Act of 1979 (Public Law 95-457) was the first Federal law to pay directly for services provided by CNMs without either referrals or direct supervision by physicians.

Federal Employees Health Benefit Program.—Of the 21 FEHBP fee-for-service plans, 20 cover CNMs without a contractual requirement for physicians' referrals or supervision. In addition, many prepaid plans in the FEHBP employ CNMs. Roughly **90** percent of all Federal enrollees are in plans that cover CNMs **(256).** Many of the insurance companies in the FEHBP offer the same coverage of CNMs for their private sector business.

Private Insurance

Private third-party payment for CNMs' services has also been mandated in a growing number of jurisdictions. As of 1983, 14 States had mandated direct reimbursement by private insurers for CNMs' care (55), By April 1986, the number of States had increased to 17 (11). In most States, direct supervision by physicians is not a condition of reimbursement (22). In addition, "in many other States insurers voluntarily have chosen to pay for nurse-midwifery care" (55). Fifty-seven percent of the large corporations surveyed by the Washington Business Group on Health provide direct reimbursement to CNMs **(91).**