NURSE-MANAGED HEALTH centers (NMHCs) represent a promising new model for the health care safety net in the United States. Staffed and managed by nurse practitioners (NPs) and other advanced practice nurses (APNs), health centers provide primary care, health promotion, and disease prevention services in rural and urban areas with limited access to health care. Although NMHCs provide cost-effective primary care with comparable patient outcomes to physician-managed health centers, they must overcome unique and significant economic and professional barriers to sustain their practice (Mundinger et al., 2000).

In our health care system today, economics and law play a large role in determining the health care options for particular communities. The nursing profession has a long history of providing holistic, community-based health care to disadvantaged populations, and this tradition continues every day through the work of APNs and nurse practitioners in NMHCs and other community-based settings (National Nursing Centers Consortium [NNCC], 2005).

Despite the fact that NMHCs address some of the most widely pursued goals in health care policy today, such as elimination of health disparities, their work is commonly undervalued by managed care companies, the majority of which refuse to credential NP staff as primary care providers. These prohibitive policies reduce nurse-managed health centers’ capacity for growth and, in turn, threaten the long-term sustainability of a key component of this country’s health care safety net.

In an attempt to better understand the landscape of managed care policies regarding primary care nurse practitioners, the NNCC embarked on a 2-month study and survey of over 200 major health care insurance companies in 47 states and the

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**Executive Summary**

- Nurse-managed health centers and nurse practitioners (NPs) have demonstrated their ability to provide comparable quality and greater access to care for underserved communities.
- A survey of 112 HMOs revealed that only 33% of HMOs have a policy for NP credentialing as primary care providers, only 40% of companies with managed Medicaid credential NPs as primary care providers, and only 52% of those with NPs as primary care providers reimburse them at the same rate as primary care physicians.
- Laws exist in some states requiring insurance companies to contract with “any willing provider (AWP) willing to meet the insurer’s terms” and/or “any willing class of providers (AWCP),” prohibiting discrimination based upon training or licensure.
- Despite the existence of similar federal laws, few laws are ever enforced.
- In states where NPs have a more extensive scope of practice in terms of prescriptive authority and independent practice, the more likely managed care organizations (MCOs) are to credential NPs as primary care providers.
- If preserving and expanding this approach to reducing health disparities is fully embraced, states must ensure NP independence and MCOs must recognize anti-provider discrimination laws by credentialing and fully reimbursing NPs.

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District of Columbia. Such a comprehensive, broad-scope study of managed care policies regarding primary care nurse practitioners was unprecedented and the results of the study were troubling.

**Managed Care and Health Care Financing in the United States**

Access into the managed care market “resides in the political and legislative arena controlled by state and federal bodies and is strongly influenced by organized medicine’s ability to control the dialogue and language of reimbursement” (Mezey, Greenberg, McGivern, & Sullivan-Marx, 2003, p. 12). For example, the American Medical Association (AMA) develops and controls the current coding system, Current Procedure Terminology (CPT), to process patient claims for payment. The allowable medical claims are built to suit a medical model of care, where a provider is funded to treat an illness, but not to do preventive health. Thus, AMA remains in the driver seat as to what types of health care services primary care providers can be reimbursed for. “The key to GRNP’s unequivocal market access rests in the ability to bill third-party insurers independently and receive equitable pay for their services” (Mezey et al., 2003, p. 12).

In 2004, 163 million people in the United States were enrolled in commercial insurance plans (Waller, 2004). A staggering 90% of those people received their health benefits through a managed care plan (Rich & Erb, 2005). Although the managed care model began among commercial insurance plans, state governments trying to control rising Medicaid costs have passed laws and regulations in the past decade to promote the spread of managed care among publicly funded health care programs as well (Rich & Erb, 2005). According to a 2005 report from the Centers for Medicare and Medicaid Services, 39 states have shifted the majority of their Medicaid beneficiaries into managed care plans.

Managed care penetration among Medicare beneficiaries is also expected to rise in the coming years. Unlike many Medicaid beneficiaries, Medicare beneficiaries are not required to enroll in an health maintenance organization (HMO) to receive services; this may be one of the major reasons why managed care enrollment is not nearly as pervasive among Medicare beneficiaries as it is among Medicaid beneficiaries. In 2004, only 12.7% of Medicare beneficiaries in the United States were enrolled in Medicare managed care plans (officially known as the Medicare Advantage program). However, recent legislative activity shows that the federal government is eager to increase private insurer participation in the program. In 2004, the federal government increased payment for Medicare services to entice more private insurers to take part in Medicare Advantage. The Department of Health and Human Services, Centers for Medicare and Medicaid Services predicted that the percentage of Medicare beneficiaries enrolled in Medicare Advantage will more than double within the next 8 years (Tu, 2005).

Many health insurance companies have multiple product lines for both commercial buyers and public program beneficiaries. Many insurance companies, however, employ the same credentialing policies for all product lines, regardless of whether enrollees receive their health benefits through Medicaid, Medicare, or their employer. Thus, the popularity of managed care in both public and private sectors created an environment where one large private company’s policies can significantly impact the way health care is delivered to all people in the United States (including non-enrollees). Such is the case of NMHCs, whose long-term financial sustainability is threatened because private insurance companies often refuse to recognize and reimburse NPs as primary care providers.

**Survey Methodology**

The survey target list was compiled using The Interstudy Competitive Edge 13.1 HMO Directory (March 2003). Surveyors compiled a contact list comprising the top ten plans (in terms of total enrollment) in each state offering HMO health insurance products, according to the directory. During the survey, however, research revealed that mergers, name changes, and shut-downs took place since the directory was published. These changes were noted on the survey contact list and taken into consideration while compiling data. The study’s survey sample is a representative cross-section of the largest and most influential managed care plans in the country today.

Over the course of 2 months, telephone calls were placed to 206 managed care companies in 49 states and the District of Columbia. Where possible, public relations or other corporate-level managerial staff members were surveyed. In other cases, the survey was conducted using the company’s general phone number and allowing the receptionist to direct the call to the appropriate person. When this was the case, the call was often transferred to credentialing, contracting, or human resources departments within the company. Many of the largest managed care companies operate plans in multiple states. Where possible, the study sought corporate headquarters staff to explain the company’s policies in each state. Despite the fact that many large managed care companies have standardized policies that do not vary significantly from state-to-state, this survey counts each plan in each state as a separate entity.

Unfortunately, survey response was low. Out of the 206 health care plans that were contacted, only 112 chose to participate in the survey (a 54% response rate). Five plans explicitly refused to participate in the survey. The rest
### Insurer Policies Create Barriers to Health Care Access and Consumer Choice

#### Table 1.
**Common Barriers to Nurse-Managed Health Center Practice**

<table>
<thead>
<tr>
<th>Scope of Practice Barriers</th>
<th>Inadequate Legal Protection</th>
<th>Discriminatory Managed Care Policies</th>
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<tr>
<td>In states that require more extensive physician collaboration, nurse practitioners (NP) are less likely to be credentialed as primary care providers (PCPs).</td>
<td>State regulation of MCOs in the form of Any Willing Provider laws (AWP) provides little protection for NPs. Most state AWP laws either do not apply to NPs or contain too many exceptions to guarantee that NPs will be credentialed as PCPs.</td>
<td>Many MCOs have enacted internal policies prohibiting the credentialing of NPs as PCPs. These policies are in effect in many states where the use of NP PCPs is permitted if not encouraged by state law.</td>
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<td><strong>Fact:</strong> 78% of managed care organizations (MCOs) in states that allow NPs to practice independently credential NPs as PCPs, as compared to only 17% in states that require physician supervision.</td>
<td><strong>Fact:</strong> Only 43% of MCOs in states that have AWP laws which either explicitly or arguably apply to NPs credential NPs as PCPs.</td>
<td><strong>Fact:</strong> Approximately 60% of MCOs in the survey sample do not credential NPs as PCPs, even when it is permitted by state law.</td>
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<td>In states that restrict the ability of NPs to independently prescribe medications, NPs are less likely to be credentialed as PCPs.</td>
<td>Many states have also enacted Any Willing Class of Provider (AWCP) laws. These laws forbid MCOs from discriminating against a particular class of providers (such as NPs) based on their training or licensure. These laws provide even less protection for NPs than AWP laws.</td>
<td>There is a general lack of transparency as to the reasons why MCOs choose not to credential NPs as PCPs, which suggests a discriminatory intent.</td>
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<td><strong>Fact:</strong> In states where NPs are not explicitly permitted by law to prescribe drugs, not one single MCO credentials NPs as PCPs, as compared to 64% in states where NPs are permitted to prescribe drugs without physician involvement.</td>
<td><strong>Fact:</strong> MCOs in states with AWCP laws are actually less likely to credential NPs as PCPs than are MCOs in states with no anti-provider-discrimination laws.</td>
<td><strong>Fact:</strong> Out of 206 MCOs contacted, only 54% chose to participate in the National Nursing Centers Consortium’s study. Of the MCOs that did participate, 11 declined to provide a rationale for why they do not credential NPs as PCPs.</td>
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<td>Other scope of practice limitations (such as lack of hospital admission privileges) contribute to the inability of NPs to become PCPs.</td>
<td>Federal MCO regulations are also ineffective when it comes to assuring that NPs will be credentialed as PCPs.</td>
<td>MCOs cannot provide a uniform rationale for not credentialing NPs as PCPs. The reasons cited for these policies often run the gamut from legal considerations to company tradition.</td>
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<td><strong>Fact:</strong> 28% of the MCOs that provided a reason for why they do not credential NPs as PCPs cited their belief that NPs do not provide the same scope of services as do physicians in support of their policy.</td>
<td><strong>Fact:</strong> Despite the existence of a federal AWCP law only 60% of Medicaid MCOs credential NPs as PCPs; the percentage of Medicare MCOs is even lower at 24%.</td>
<td><strong>Fact:</strong> One major health plan’s credentialing policy varies on a county by county basis, and four of the MCOs surveyed provided rationales based on inaccurate information.</td>
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In cases where managed care companies either explicitly refused to participate, gave suspect answers, or did not respond after repeated contact attempts, surveyors contacted health care professionals working in the local areas served by the non-responsive health plans. Surveyors contacted NMHC directors and staff to determine the credentialing and reimbursement policies of non-responsive plans. These data were included in the final survey sample.

The final survey sample, with all of the above considerations taken into effect, includes 117 managed care plans in 47 states and the District of Columbia. Table 1 shows some of the study’s key findings along with the most common barriers preventing NPs from being credentialed as primary care providers and inhibiting the expansion of nurse-managed health centers.
center practice. These barriers are discussed in greater detail within the body of this article. Other survey findings include:

- Only 33% of managed care companies have a uniform policy allowing NPs to be credentialed as primary care providers.
- 40% of Medicaid managed care companies credential NPs as primary care providers.
- Among plans that admit NPs to their networks as primary care providers, only 52% reimburse them at the same rate as primary care physicians.
- A significant number of managed care company representatives appeared to have difficulty understanding how a NP could even be capable of acting as a primary care provider.

If a CRNP has not been credentialed by a managed care company as stated, she/he must bill the company for her/his services under a physician’s name, even if she/he has provided the care with very little or no physician involvement. When she/he bills under a physician’s name, the managed care company will pay for services at the full physician rate; however, the CRNP is not a party to the transaction. Instead of being paid directly for the care provided to the insurance company’s enrollee, all of the reimbursement from the insurance company will go to the physician associated with the practice. This makes CRNP care invisible to managed care companies, which in turn contributes to managed care policies that continually fail to recognize the work of CRNPs. This rationale behind this billing process assumes CRNPs work in physician offices where they are closely supervised by physicians. However, this is not the case in nurse-managed health centers.

Medicaid and Medicare began as fee-for-service programs. However, as managed care spread through the commercial sector, state and federal government entities began looking to managed care models to contain rising program costs. As a result, nearly 75% of Medicaid beneficiaries in the country currently receive their benefits through a managed care organization (MCO) (The Henry J. Kaiser Family Foundation, 2004). Current law requires fee-for-service Medicaid to cover health care services provided by some APNs. The Balanced Budget Act of 1997 (BBA, P.L. 105-33) encouraged states to move Medicaid recipients into managed care and to use primary care case managers as gatekeepers in fee-for-service. However, despite congressional intent, it failed to fully recognize APNs and particularly CRNPs as participants in these plans. While the act encouraged states to ensure that CRNPs and other APNs are included in managed care provider panels, the fact that only 40% of Medicaid managed care companies include CRNPs shows that this policy has failed.

The most popular reason for not credentialing NPs is based on weak state laws, which do not require managed care companies to credential CRNPs. Thus, a current House and Senate bill would require that states make it mandatory for CRNPs to be credentialed with state-contracted Medicaid insurance companies [S. 1515, 108th Cong. (2003) & H. 2617, Cong. (2005)].

Managed care company credentialing and reimbursement policies are the single biggest barrier for nurse-managed health center practice that exists today. Such policies prevent CRNPs from functioning to the fullest extent of their abilities and interfere with nurse-managed health center patients’ access to care. The problems created for NMHCs by managed care policies that exclude nurse practitioners from provider networks are often compounded by an obscure credentialing process, the lack of an efficient appeal process, and staff misinformation about the role of CRNPs as primary care providers.

There are conceivably thousands of state and federal laws that regulate the health care industry, affecting every type of health care professional and entity from providers to managed care companies to hospitals. Health care professionals, by virtue of working in such a highly regulated industry, may often find their everyday practice affected by a vast network of loosely coordinated state and federal laws. Thus, in addition to surveying managed care companies about their policies, researchers examined a few of these laws and attempted to determine which had the greatest impact on managed care credentialing and reimbursement policies.

**State Regulation of Managed Care Companies: Any Willing Provider And Any Willing Class of Provider Laws**

Twenty-three states currently have some form of “Any Willing Provider” (AWP) laws, which offer insurance companies the ability to contract with any willing provider willing to meet the insurer’s terms and conditions (Levy, 2003). Managed care companies oppose AWP laws on the grounds that they reduce company bargaining power and drive up the cost of health care by effectively eliminating exclusive provider networks (Kentucky Association of Health Plans v. Miller, 2003). Unlike AWP laws, “Any Willing Class of Provider” (AWCP) laws do not prohibit managed care companies from creating exclusive provider networks, but they forbid insurers to discriminate against a particular class of providers based on their training or licensure (Levy, 2003). Many nonphysician practitioners have fought long and hard for laws such as these (American College of Nurse Midwives, 2005). However, because of steady opposition from the managed care industry, there are relatively few AWP/AWCP laws in existence.
today. Among the states that have AWP/AWCP laws, many refer specifically to dentists, pharmacists, physicians, and/or chiropractors — not advanced-practice nurses (Levy, 2003). The remaining AWP/AWCP laws that either explicitly or arguably apply to NPs show the effects of managed care opposition, in the form of qualifying language that significantly weakens their reach and scope. Many of the nursing professionals interviewed for this article characterized the AWP/AWCP laws in their states as “really weak” or “unenforced.”

Figure 1 shows just how little concrete protection AWP and AWCP laws provide for primary care NPs. In states with no AWP/AWCP legislation, approximately one in every three HMOs credential NPs as primary care providers. Approximately 30% of those plans that credential primary care NPs reimburse them at the same rate as primary care physicians.

HMOs in states with AWP laws were somewhat more likely to credential NPs as primary care providers. Despite the existence of an AWP law, however, the majority of HMOs in these states do not credential NPs as primary care providers. Furthermore, HMOs in states with AWP laws were significantly less likely than HMOs in non-AWP states to reimburse nurse practitioners at the same rate as primary care physicians. Although AWP laws may have some small positive impact on HMO credentialing policies, they do not appear to positively affect NP practice in a broader sense.

Even more surprising, it appears as though AWCP laws correlate with prohibitive credentialing policies on the part of managed care companies. HMOs in states with AWCP laws are actually less likely to credential primary care NPs and reimburse them at the same rate as primary care physicians than HMOs in states with no anti-provider-discrimination laws. For whatever reason, the existence of AWCP laws seems to coincide with prohibitive managed care policies. Although they have been touted as a means to stop managed care discrimination, AWCP and AWCP laws seem to provide little to no tangible protection to primary care nurse practitioners. In some cases, anti-provider-discrimination laws coincide with managed care credentialing and reimbursement policies that are worse than the norm for NPs.

Federal Regulation of Medicaid And Medicare Managed Care Companies: Anti-Provider-Discrimination Laws

Medicaid and Medicare began as fee-for-service programs. However, as the managed care revolution spread through the commercial sector, state and federal government entities began looking to managed care models to contain rising program costs (Zarabozo, 2000). As a result, nearly 75% of Medicaid beneficiaries in the country currently receive their benefits through a managed care organization. Thirty-five percent of all Medicaid beneficiaries receive their benefits through an MCO that offers commercial insurance products in addition to Medicaid plans (The Henry J. Kaiser Family Foundation, 2004). The Medicare program began to shift to the managed care model more recently. While only 13% of the nation’s 40 million Medicare beneficiaries are currently enrolled in the Medicare Advantage Managed Care program, that number is expected to rise significantly in the coming decade (Tu, 2004).

Although some of the plans in the survey sample catered to only commercial customers or Medicaid recipients, most of the managed care companies in the survey sam-
ple offered multiple product lines. Most of the plans that offered commercial product lines also offered either Medicaid or Medicare product lines as well. In some cases, managed care companies offered plans designed for all three categories of health insurance consumers. All of the companies that were surveyed, however, used the same provider panel for their commercial enrollees as for their Medicaid and/or Medicare enrollees. Thus, if a primary care NP cannot gain admittance to a particular plan’s provider panel, she most likely cannot be a primary care provider for any enrollee in the plan, regardless of whether the enrollee received health benefits through his employer or a publicly funded program.

There are federal regulations, extremely similar to many of the AWCP state laws discussed previously, that prohibit certain forms of provider discrimination among Medicaid and Medicare MCOs (42 C.F.R. § 438.12 (2005) [Medicaid]; 42 C.F.R. § 422.205 (2005) [Medicare Advantage]). The two statutes are virtually identical, and both prohibit provider discrimination “solely on the basis of [a provider’s] license or certification.” As explained previously, the addition of the phrase “solely on” reduces the amount of concrete protection that the statute provides to primary care nurse practitioners.

While many state AWCP laws do not refer explicitly to both provider network participation and reimbursement, both the Medicaid and the Medicare Advantage anti-provider-discrimination statutes do. Despite this, however, there are very significant qualifications attached to both of the statutes that strip them of much of their power.

The Medicare Advantage anti-provider-discrimination statute (42 C.F.R. §42.205), in addition to the language cited previously, also states that the statute “does not preclude” any Medicare Advantage MCO from refusing to admit providers to its network that are “in excess of the number necessary to meet the needs of the plan’s enrollees.” The statute also indicates that it does not preclude the “[use of different reimbursement amounts for...different practitioners in the same specialty.” In other words, under this statute, managed care companies need not admit NP's to their provider panels so long as they can show that the nebulously defined “needs” of their enrollees are being met by their existing provider network, and managed care companies need not reimburse primary care nurse practitioners and primary care physicians at the same rate.

Like the Medicare Advantage anti-provider-discrimination statute, the Medicaid anti-provider-discrimination statute (42 C.F.R. §438.12) indicates that it “may not be construed to...require [an] MCO...to contract with providers beyond the number necessary to meet the needs of its enrollees.” It also states that the statute may not be construed to “[p]reclude the MCO...from using different reimbursement amounts for...different practitioners in the same specialty.” However, unlike the Medicare Advantage statute, the Medicaid anti-provider-discrimination law references another nondiscrimination provision in the Code of Federal Regulations that prohibits MCO discrimination “against particular providers that serve high-risk populations.”

However, the study indicates that these federal anti-provider-discrimination laws have limited or no effect on the credentialing and reimbursement policies of managed care companies serving Medicaid and Medicare managed care enrollees. Figure 2 shows that 24% of managed care companies that offer only commercial products credential NPs as primary care providers. Despite the existence of an anti-provider-discrimination statute, managed care companies that offer Medicaid Advantage plans are no more likely than commercial-only companies to credential NPs as primary care providers.

Companies that offer plans for Medicaid beneficiaries are more than twice as likely to credential primary care NPs than companies that do not offer Medicaid plans. However, survey results also indicate that nearly half all MCOs offering Medicaid plans do not creden-
Insurer Policies Create Barriers to Health Care Access and Consumer Choice

Figure 3. Relationship Between Nurse Practitioner (NP) Prescriptive Authority and HMO Credentialing Policies

<table>
<thead>
<tr>
<th>Percentage of HMOs Within Each Category Credentialing NPs as PCPs</th>
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<tr>
<td>70%</td>
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<td>60%</td>
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<td>10%</td>
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■ States explicitly authorize NP prescription powers (no MD involvement required)
■ States explicitly authorize NP prescription powers (MD involvement required)
■ States require MD to “delegate” prescription powers to NPs

Figure 4. Relationship Between Physician Collaboration Requirements and HMO Credentialing Policies

<table>
<thead>
<tr>
<th>Percentage of HMOs Within Each Category Credentialing NPs as PCPs</th>
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<tbody>
<tr>
<td>90%</td>
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<tr>
<td>80%</td>
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<td>70%</td>
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■ State law requires NP to be “supervised” by physician
■ State law requires NP to “collaborate” with physician
■ State does not require physician involvement for NP practice

Researchers found that of the most popular reasons cited by MCO staff for instituting prohibitive credentialing policies was the belief that nurse practitioners are incapable of providing the full scope of services that primary care physicians provide. Many of the survey participants who cited this reason specifically referenced state-imposed limits on NPs’ prescriptive authority and state law requirements regarding physician collaboration. Interestingly enough, it was these types of laws that had the highest correlation to favorable credentialing policies.

State Regulation of NPs: Scope of Practice and Physician Collaboration Requirements

Researchers found that the most popular reasons cited by MCO staff for instituting prohibitive credentialing policies was the belief that nurse practitioners are incapable of providing the full scope of services that primary care physicians provide. Many of the survey participants who cited this reason specifically referenced state-imposed limits on NPs’ prescriptive authority and state law requirements regarding physician collaboration. Interestingly enough, it was these types of laws that had the highest correlation to favorable credentialing policies.

Figure 3 shows the relationship between HMO credentialing policies and state laws governing prescriptive authority for NPs. In states where nurse practitioners are not explicitly permitted by law to prescribe drugs, not one single HMO credentialled NPs as primary care providers. Meanwhile, 64% of HMOs in states where NPs are permitted to prescribe drugs without physician involvement credential NPs as primary care providers.

Figure 4 shows a similar correlation between NP independence and managed care company credentialing policies. In states that require physician supervision of NPs, only 19% of HMOs credential primary care NPs. In states that allow nurse practitioners to prac-
tice independently, 78% of HMOs credential NPs as primary care providers. In short, as nurse practitioner practice becomes more independent under state law, managed care companies become much more likely to credential NPs as primary care providers.

Conclusion

In order for nurse-managed health centers and nurse practitioners to continue to provide primary health care services in underserved areas, NPs must be placed on equal financial footing with primary care physicians. To achieve this goal, NPs and others who support innovative community health initiatives must band together to remove financial barriers to nurse-managed health center practice.

With over 45 million uninsured people in the United States, it is in both state and federal governments’ interest to promote increased access to health care. If the federal government were to enforce the anti-provider-discrimination laws that currently exist and take a stronger stance against Medicaid and Medicare Advantage managed care contractors that discriminate against NPs on the basis of licensure, NMHCs would be able to focus their energy on providing health care to underserved populations instead of fighting unfair managed care policies. Alternatively, passing new laws that specifically require managed care companies to credential NPs as primary care providers, if stringently enforced, would also have a positive impact on NMHC practice.

Discrimination against NPs who provide care to underserved communities is, in effect, a form of hidden discrimination against the poor that interferes with health care access and choice for uninsured and underinsured populations. Much has been written about health care disparities in urban and rural communities and the need to do something about it. Nurse-managed health centers provide much-needed health care to over 1.5 million people each year in urban and rural communities throughout the country. By encouraging their growth, we can do something about health care disparities and increase access to quality health care in underserved areas. If NMHCs receive fair compensation for the care that they already provide every day to managed care enrollees, we can ensure the long-term sustainability of these important safety-net providers.

REFERENCES


Use of Ill-Time

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