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# Massachusetts Nurse Practitioners Step Up as One Solution to the Primary Care Access Problem

## A Political Success Story

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Massachusetts' political experience with efforts to insure all citizens provided a unique opportunity for nurse practitioners to address the growing need for access to primary care. Passage of a new statute to recognize nurse practitioners as primary care providers that health plan beneficiaries could choose was accomplished through strategic planning and political savvy. The results of a focused effort using the expertise of a professional lobbying team along with organizational support resulted in a groundbreaking new law that is a component of a reform model being examined by the nation as a whole, looking to address accessible, quality, and affordable health care. This article chronicles that journey and its accomplishment.

**Keywords:** *Advanced nursing practice; Coverage/access; Political action; Private health plans; Medicaid; State legislation*

### Massachusetts Moves to Insure Everyone

As public concern about health care access and costs has grown, increasing attention has focused on health care reform adopted in Massachusetts in 2006 as a possible model for national health reform. The landmark state law, Chapter 58 of the Acts of 2006, titled "An Act Providing Access to Affordable, Quality, Accountable Health Care," was intended to bring Massachusetts close to universal insurance coverage by expanding the state's Medicaid program, imposing a mandate on all Massachusetts citizens to acquire health insurance coverage and subsidizing coverage for those who could not pay it for themselves. It has achieved notable success in expanding health care insurance enrollment and providing access to medical care without decreasing enrollment in private health insurance. The Massachusetts program has also experienced higher than anticipated costs (Holahan & Blumberg, 2008). To examine its impact, the Blue Cross Blue Shield of Massachusetts Foundation, the Commonwealth Fund, and the Robert Wood Johnson Foundation contracted with the Urban Institute to develop and implement a new survey of enrollees to renew cost estimates associated with both the number of uninsured and the number of people within the income eligibility range for program participation.

A report discussing the survey findings noted that

Massachusetts is encountering the same increases in health care costs that plague the nation as a whole, as well as inefficiencies in its health care delivery system that predate the 2006 reform. The Massachusetts experience shows that major coverage expansions can be undertaken without addressing costs and provider constraints, but these factors, if they are not addressed eventually, can undercut the benefits from gaining insurance coverage by reducing access to care and the affordability of care. (Long and Masi, 2009)

Despite concerns about costs, the Urban Institute reports that public support of the program remains high at 70%.

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**Authors' Note:** Gloria Craven and Stacey Ober are principals of Craven & Ober Policy Strategists, LLC, a full service Massachusetts-based government relations firm. The authors' firm is retained by the Massachusetts Coalition Nurse Practitioners (MCNP) to provide lobbying services. It represented MCNP in successful passage of the legislation described in this article. Please address correspondence to Gloria Craven, Craven & Ober Policy Strategists, LLC, 6 Beacon Street, Suite 600, Boston, MA 02108; e-mail: [GCraven@policystrategists.com](mailto:GCraven@policystrategists.com).

## Access to Health Insurance Does Not Equal Access to Care

Prior to the passage of Massachusetts Health Reform legislation in 2006, the Massachusetts Medical Society had published reports of their annual survey showing that the number of patients waiting longer than 8 weeks to see a primary care physician had grown to 16% (Massachusetts Medical Society, 2006). This survey was intended as a political substantiation for public policy changes in the areas of medical malpractice and the physician workforce, including a rationale for higher compensation and strategies for physician recruitment to certain specialties, in addition to highlighting the shortages of primary care physicians.

At the time that the Massachusetts Medical Society was making the case for addressing the shortage of primary care physicians, the Massachusetts Coalition of Nurse Practitioners (MCNP) filed legislation to formally recognize nurse practitioners (NPs) as primary care providers (PCPs), as another solution to the shortage of PCPs in the state. This shortage was exacerbated after the passage of Chapter 58 because more Massachusetts citizens became enrolled in insurance plans. Although the Massachusetts Nurse Practice Act (M.G.L. c 112 § 80B) authorized NPs to act as PCPs and the state Medicaid program (in compliance with federal rules prohibiting provider discrimination) formally recognized NPs as PCPs, only Medicaid managed care organizations actually used NPs as participating network PCPs. When private insurance carriers' provider directories were examined, no NPs were found listed as PCPs. In fact, the internal policy of one New England carrier noted that without exception, it would only recognize physicians as PCPs unless state law required otherwise (Harvard Pilgrim Health Care of New England, 2005-2006). This same carrier published a New England-wide provider directory for beneficiaries that listed NPs in New Hampshire and Maine among the primary care physicians listed in those states. However, in the Massachusetts section of the directory, only physicians were listed as PCPs. This illustrates discriminatory practices experienced by Massachusetts NPs without a statute mandating recognition of their scope of practice. In an attempt to increase transparency, one Massachusetts primary care practice group that had been experiencing difficulty opening its practice to accept new patients took out a half page advertisement in a local newspaper announcing they had recently hired a family nurse practitioner and would now be accepting new patients (Chatham PrimaryCare, 2005). This newspaper advertisement further demonstrated the limited opportunities available to the public for both

identifying and choosing an NP as their PCP while publicly substantiating the legitimacy of recognizing and accepting the NP as a PCP.

In filing its legislation, MCNP's goal was to address access to primary care problems by increasing consumer choice of NPs. MCNP's stance was that even when citizens may have insurance coverage, they may still be without adequate access to a PCP.

## The Politics of Change: Careful Construction of Legislative Text

Under the Massachusetts Nurse Practice Act, NPs practice in collaborative practice agreements with physicians. A survey of MCNP members found that most NPs were content with this collaborative model for advanced nursing practice in Massachusetts. The legislation filed was not designed to change this collaborative model or the scope of nursing practice. However, NPs were troubled by the lack of public transparency and carrier recognition with regard to identification of the NP on the provider network and what services they are authorized by state law to provide. For these two reasons, the basic concepts of transparency and choice became the centerpieces for the legislation, first filed as "An Act Providing Consumer Choice of Nurse Practitioner Services." The bill mandated recognition of the NP as a PCP. It was proposed for consideration during the formal 18-month 2005-2006 legislative session. During that same time frame, other health care stakeholders were filing legislation on behalf of their own disciplines and agendas. Because of long-standing political experience whereby significant policy changes are negotiated by large health care stakeholders, often excluding nursing at the decision-making table, drafting this legislation required strategic thinking taking into consideration major changes occurring in the Massachusetts health care political climate. Historically the nursing profession has often been left to respond to legislation proposed by others, which has often then required years of lobbying to correct some negative consequence. Thus our strategic thinking included an assessment of other bills that could have a negative impact on the progress we were seeking for NPs as PCPs. Fortunately, MCNP had previously identified a legislative initiative to codify a streamlined physician credentialing process that might have created physician exemption to the antitrust laws when negotiating provider network contracts. Because credentialing is tied to reimbursement, we understood that this legislation could be quite harmful to the other health providers, including NPs. This bill had been promoted by The Massachusetts

Medical Society as a simple administrative simplification bill rather than one related to antitrust exemptions. Because of its support from the Massachusetts Association of Health Plans and the Massachusetts Hospital Association, the issue had become a political lightning rod in Massachusetts and a real conundrum for MCNP. The MCNP alerted lawmakers and the Attorney General of the implications of the bill and addressed this potential harm with written testimony. If there had been Massachusetts statutory language creating a credentialing process for physicians, MCNP would have sought similar language for NPs. Massachusetts carriers did not universally credential NPs because the National Committee for Quality Assurance standards for health plan accreditation permit but do not require credentialing of NPs. Furthermore, Massachusetts does not have a uniform process codified in law for credentialing health care providers. Therefore, when we developed our legislation, we decided not to address the issue of credentialing, even though we understood that many carriers had routinely used their credentialing processes to discriminate against non-physician providers, often excluding whole categories of providers from their networks. Instead, we strategically drafted our bill to mandate that all carriers recognize NPs, practicing within their scope of practice, as meeting the definition of primary care provider. Once our bill passed, any NP formally recognized as a participating PCP in the provider network and listed in the health plan directory would, warrant credentialing by the carrier. This strategy increased the likelihood of bill passage by not getting caught up in the issue of whether to codify a credentialing process outright, focusing instead on the issues of consumer choice and transparency.

Another strategy was to give our legislation, once passed as a new chapter in the General Law, the ability to survive future legislative health care policy changes. History had demonstrated that when the nursing profession takes the lead on a legislative proposal, often a relevant section of existing law is overlooked or an important section of the proposal is negotiated away when attempting to secure sufficient support to enact it. One important example is that when legislation providing third-party reimbursement for NPs was enacted in 1994, it failed to list the Group Insurance Commission (which provides health insurance coverage for employees of many state and local agencies) among those plans required to pay for NP services. Rather than attempting to amend every relevant section of insurance law to include NPs as PCPs with this bill and recognizing that this approach would create the risk that future, unanticipated changes to the insurance market could again leave

NPs out of the mix, we decided to establish a new, separate chapter of the insurance laws to create a statutory definition of primary care provider and to expressly include NPs in the role. This careful construction of legislative text matched our objective to mirror standard statutory insurance definitions such as "carrier" so that policy makers would incorporate these definitions by reference when making any future changes affecting carriers across the board. The new NP chapter in insurance law also provided the opportunity to correct the Group Insurance Commission omission by creating a broad requirement that all carriers provide reimbursement for NP services.

In addition, by focusing on the creation of a new chapter in the insurance law rather than amending the Nurse Practice Act, we made it clear that we were not proposing changes to NPs' current legal authority to practice or their collaborative practice model in Massachusetts. By pointing to the Medicaid regulations already in place and the handful of examples of NPs being used by Medicaid as PCPs, we showed that NPs already had authority under the current Nurse Practice Act to practice as PCPs. And because we were not proposing changes in the current collaborative practice model for NPs, we relieved any anxiety that the legislation was designed to take money away from physician or hospital practice groups that employ NPs. In fact, these physician groups and hospitals would have strong incentives to negotiate and argue for equal pay for equal work provided by NPs. Again, careful drafting of the text made certain that carriers must provide coverage for NP services on a nondiscriminatory basis to their insureds, by making it clear that any service provided under the carrier benefits would be covered, when provided by an NP practicing within the scope of his or her professional license. The goal was to avoid provider contracts with carriers that limit the types of services NPs practicing as PCPs could perform and to secure appropriate compensation for NP services. Furthermore, the legislation provided that the new statute would be enforced by regulations promulgated by the Division of Insurance and the Group Insurance Commission.

The Legislature spent the majority of the 2005-2006 session brokering fragile alliances and consensus behind the scenes among business leaders, hospital systems, and organized medicine on how to structure the state's historic health reform initiative. MCNP actively used this time to educate legislators about the fact that NPs were providing primary care services, preventive care, and disease management but were unaccounted for in the current system. We provided copies of plan directories to demonstrate this inconsistency. Furthermore, NPs had

enjoyed mandated insurance coverage for their services for more than a dozen years and despite an increasing emphasis on pay for performance and transparency of clinical outcomes data, the claims data on which these are based often failed to distinguish whether services were provided by NPs or their collaborating physician. MCNP successfully argued that this lack of accuracy and accountability was untenable. Many legislators agreed and several relayed their own personal experiences of receiving services directly from the NP with great satisfaction. Lawmakers' understanding that plan directories without NPs listed prevented them from sustaining a professional relationship with their NP if and when the NP changed employer was important. At the same time, the Massachusetts Department of Public Health (DPH) was in the process of approving regulations allowing NPs to provide care in retail clinics. Although the retail clinic debate proved controversial, awareness of the competence of the NP in delivering primary care was bolstered by the public's support and by the eventual adoption of new regulations by the DPH to allow the establishment of limited service retail clinics staffed by NPs. Public approval and credibility of NP practice was further enhanced by the pharmacy chain advertisement campaign that quickly followed.

### **Political Support: A Needed Component for a Successful Outcome**

Senate President Therese Murray (D-Plymouth), a key policy maker responsible for the landmark 2006 Massachusetts health care reform law, sponsored a package of legislative proposals in 2007—referred to as Healthcare Reform II—designed to help sustain the reform by containing costs, ensuring transparency, and promoting efficiency. The Senate Chair of the Joint Committee on Public Health, Senator Susan Fargo (D-Lincoln/Lexington), was our Senate bill sponsor, and she was instrumental in securing our bill's favorable release early in the legislative calendar. This confluence of circumstances created a strong political opportunity for inclusion of our legislation in the Senate President's referred to as Healthcare Reform II package (see the appendix).

The problem of access for Massachusetts citizens became larger than any one stakeholder or legislator whose tendencies were to oppose the NP's proposal. Using the Massachusetts Medical Society's own statistics verifying the scope of the access problem allowed MCNP to successfully dismiss organized medicine's continued opposition to using NPs as PCPs. This strategy

left organized medicine without a credible voice regarding this aspect of the Legislature's debate. The health plans, however, are dominated by physicians who function as executive staff and as members of boards of directors. Some health plans mounted the greatest challenge to our effort. Fortunately, the political question had become how, not whether, to enact our NP as PCP proposal.

Interestingly we learned that the health insurance industry trade group did not oppose our legislation. However, as passage became inevitable, attorneys for the individual health plans were weighing in with the Legislature, offering amendments they claimed were not substantive but absolutely necessary. Some of these included provisions stating that no insurer would have to employ any additional NPs in the future, and that only NPs currently under contract would be recognized as PCPs. One carrier attempted to water down the bill by authorizing plans to individually adopt a specific NP credentialing process that could have resulted in new hurdles for the NPs looking to be included in a provider network. Although there were many attempts to compromise the legislative language, the Senate President was dedicated to accomplishing increased access to NPs as PCPs by getting the text "right." Legislative staff in control of this process listened to the health plans' concerns and worked through the suggested language changes, allowing MCNP to respond to each proposed amendment. Network contracting between providers and health plans is clearly a highly specialized area of law. Therefore, the MCNP secured the services of an attorney who specializes in provider networks and carrier contract negotiations to join this stage of the lobbying effort. Time and again the amendments offered by the health plans appeared benign, but our attorney was adept at exposing the amendments as repeated attempts to water down or subvert the intent of the legislation. This lobbying was both intense and persistent, even until the last hours of the formal legislative session and ultimate passage of the Healthcare Reform II package in the Senate.

Massachusetts is fortunate to have four registered nurses who serve in the Massachusetts House of Representatives. Intense lobbying continued on the House side of the legislature, and Representative Jennifer Callahan (D-Sutton), who was our House bill sponsor, was instrumental in preserving the text of the initiative during the House debate on the Healthcare Reform II package, despite multiple attempts to alter it. Other nurse legislators, Representative Christine Canavan (D-Brockton), Representative Mary Grant (D-Beverly), and Representative Kay Khan (D-Newton) were very supportive in educating House members about the challenges NPs faced. One major amendment in the House, which was

successfully stripped from the final text, was to include physician assistants (PAs) as PCPs. Massachusetts PAs do not currently enjoy carrier coverage for their services and are viewed as practicing according to a physician extender model. The PA language presented multiple problems, one of which was that their addition to the text made the section far more controversial because the PAs themselves, were still focussing their politically efforts on securing advocating to secure payment for their services.

Grassroots lobbying is a key component of any campaign's success that cannot be underestimated and must be a core component of any legislative effort. MCNP members did an impressive job of implementing grassroots actions designed by the lobbying team for building support among a broad range of legislators. In addition, the MCNP used its political action committee to target attendance at and hosting of fund-raisers for key lawmakers who could assist with passage of the legislation.

### **A New Law Is Implemented and Access to Care Is the Focus**

Healthcare Reform II passed into law in August 2008 as Chapter 305 of the Acts of 2008. Statutory recognition of NPs as PCPs is one element of the new law. In addition, MCNP secured text language establishing

medical home demonstration projects that includes NPs. A new Healthcare Workforce Development Center was also created by Chapter 305 to provide loan forgiveness to physicians and NPs who concentrate their practice in primary care. Our experience shows that although you cannot necessarily change the rules of how the game of politics is played, you can play by the rules and win.

As of August 2008, Massachusetts reported that 439,000 people were newly insured with access to health care. As the new PCP provisions are implemented; Massachusetts residents will be able to identify and choose an NP as their PCP. Provider directories were mandated by regulation to identify access to NPs on their provider networks by January 2009. This change will influence both insurance and public cultural acceptance of the NP as PCP as a direct result of the new law.

As the national health care reform debate continues, unprecedented political opportunities could present themselves in other states as well. The legislative agenda and vision for any NP organization is best advanced by member participation in shaping that organization's goals and grassroots activities. Garnering that input is important to a successful lobbying effort. A lobbying team is also a critical component to stewarding legislation through its many political and legal hurdles toward a successful outcome. With focus, tenacity, professional consultation, and strategic thinking, nurses can be rest assured that our democracy does work!

**Appendix**  
**Chapter 305 of the Acts of 2008:**  
**An Act to Promote Cost Containment, Transparency and**  
**Efficiency in the Delivery of Quality Health Care**

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SECTION 28. The General Laws are hereby amended by inserting after chapter 176Q the following chapter:-

CHAPTER 176R

CONSUMER CHOICE OF NURSE PRACTITIONER SERVICES

Section 1. As used in this chapter, the following words shall have the following meanings unless the context clearly requires otherwise:

“Carrier”, an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a non-profit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; an organization entering into a preferred provider arrangement under chapter 176I; a contributory group general or blanket insurance for persons in the service of the commonwealth under chapter 32A; a contributory group general or blanket insurance for persons in the service of counties, cities, towns and districts, and their dependents under chapter 32B; the medical assistance program administered by the division of medical assistance pursuant to chapter 118E and in accordance with Title XIX of the Social Security Act or any successor statute; and any other medical assistance program operated by a governmental unit for persons categorically eligible for such program.

“Commissioner”, the commissioner of insurance.

“Insured”, an enrollee, covered person, insured, member, policyholder or subscriber of a carrier.

“Nondiscriminatory basis”, a carrier shall be deemed to be providing coverage on a non-discriminatory basis if its plan does not contain any annual or lifetime dollar or unit of service limitation imposed on coverage for the care provided by a nurse practitioner which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other participating providers.

“Nurse practitioner”, a registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under section 80B of chapter 112 and regulations promulgated there under.

“Participating provider”, a provider who, under the terms and conditions of a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to an insured with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the carrier.

“Primary care provider”, a health care professional qualified to provide general medical care for common health care problems, supervises, coordinates, prescribes, or otherwise provides or proposes health care services, initiates referrals for specialist care, and maintains continuity of care within the scope of practice.

Section 2. The commissioner and the group insurance commission shall require that all carriers recognize nurse practitioners as participating providers subject to section 3 and shall include coverage on a nondiscriminatory basis to their insureds for care provided by nurse practitioners for the purposes of health maintenance, diagnosis and treatment. Such coverage shall include benefits for primary care, intermediate care and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long-term care setting, mental health or substance abuse program, or any other setting when rendered by a nurse practitioner who is a participating provider and is practicing within the scope of his professional license to the extent that such policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth.

Section 3. A participating provider nurse practitioner practicing within the scope of his license including all regulations requiring collaboration with a physician under section 80B of chapter 112, shall be considered qualified within the carrier’s definition of primary care provider to an insured.

Section 4. Notwithstanding any general or special law to the contrary, a carrier that requires the designation of a primary care provider shall provide its insured with an opportunity to select a participating provider nurse practitioner as a primary care provider or to change its primary care provider to a participating provider nurse practitioner at any time during their coverage period.

Section 5. Notwithstanding any general or special law to the contrary, a carrier shall ensure that all participating provider nurse practitioners are included on any publicly accessible list of participating providers for the carrier.

Section 6. A complaint for noncompliance against a carrier shall be filed with and investigated by the commissioner or the group insurance commission, whichever shall have regulatory authority over the carrier. The commissioner and the group insurance commission shall promulgate regulations to enforce this chapter.

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