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Insurers' Contracting Policies on Nurse Practitioners as Primary Care Providers

Two Years Later

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A national survey showed that nearly half of all major managed care organizations in the United States refuse to credential nurse practitioners as primary care providers. In nurse-managed health centers throughout the country, nurse practitioners provide primary care to underserved populations with similar outcomes to primary care physicians. Insurers' prohibitive credentialing and reimbursement policies reduce these centers' capacity for growth and, in turn, threaten the long-term sustainability of a key component of the health care safety net. Two years after conducting a national survey of insurers' credentialing and reimbursement policies regarding primary care nurse practitioners, researchers returned to the subject matter and found that many of the same financial barriers to nurse-managed health center sustainability still exist. Although some progress had been made since 2005, this progress did not appear to be attributable to regulatory changes or renewed enforcement of existing laws.

Keywords: *managed care; provider credentialing; provider contracting; nurse-managed health centers; nurse practitioners; primary care providers*

Every year, throughout the United States, hundreds of thousands of vulnerable and medically underserved individuals access high-quality primary health care through nurse-managed health centers. Nurse-managed health centers are nongovernmental, community-based health clinics that are managed by nurses in partnership with the communities they serve. Most are either independent nonprofits or academically based clinics affiliated with schools of nursing. In these centers, nurse practitioners (NPs) provide high-quality primary care to low-income, uninsured, and underinsured patients. These centers provide cost-effective care that is comparable in quality to the care provided in traditional, physician-managed community health centers (Hansen-Turton, Line, O'Connell, Rothman, & Lauby, 2004). However, unlike other safety-net providers, nurse-managed health centers must overcome unique economic and professional barriers to achieve long-term sustainability.

Managed care policies regarding primary care NPs are one such barrier to nurse-managed health center sustainability. The work of nurse-managed health centers is often

undervalued by managed care companies, many of which refuse to credential NPs as primary care providers. Many managed care companies also reimburse primary care NPs at a lesser rate than primary care physicians, even though the providers offer substantially similar services. This discrimination persists despite the existence of state and federal laws designed to protect nonphysician providers from unfair managed care credentialing and contracting policies.

In 2005, researchers embarked on a national survey of managed care credentialing and reimbursement policies regarding NP primary care providers. The results were the subject of a 2006 article published in *Policy, Politics, & Nursing Practice* (Hansen-Turton, Begun, et al., 2006). In 2007, researchers updated this nationwide survey, the results of which are discussed in this article.

Conducted during the course of 2 months in 2007, this new survey of managed care organizations (MCOs) indicates that policies regarding NPs continue to vary widely. This article describes and analyzes surveyors' findings regarding the credentialing and reimbursement policies of 222 MCOs offering health maintenance organization

(HMO) insurance products throughout the nation. Section 2 provides an overview of the nurse-managed health center movement and the impact that managed care policies can have on the long-term sustainability of these important safety-net providers. Section 3 describes the methodology and overall findings of the study. Sections 4 and 5 describe anti-provider-discrimination laws that have been instituted at both state and federal levels and examines what impact, if any, these laws have on managed care policies toward NP primary care providers. Section 6 examines the correlation between NP prescriptive authority and managed care credentialing policies, and Section 7 outlines the authors' conclusions.

In short, the findings of this study demonstrate that many managed care companies do not consider primary care NPs to be the equal of primary care physicians and that state and federal laws designed to prohibit unfair discrimination against NPs continue to provide little protection to NP primary care providers who feel that they have been the victims of unfair discrimination. Despite increases in the number of NPs who have been able to secure better credentialing status and reimbursement, the goal of obtaining equitable credentialing and reimbursement for NP primary care providers will remain elusive as long as laws forbidding provider discrimination are not enforced and as long as managed care companies view NPs as primary care providers of last resort.

Nurse-Managed Health Centers and Managed Care Financing

In nurse-managed health centers, a combination of primary health care and comprehensive health education is provided by NPs, public health nurses, health educators, community outreach workers, and collaborating physicians. The centers are located in or near medically underserved areas in both rural and urban communities (Coleman & Hansen-Turton, 2003). The targets of service for nurse-managed health centers have traditionally been those who are underserved and least likely to be engaged in ongoing health care services for themselves and their family members.

Primary care NPs and nurse-managed health centers provide a promising opportunity to address some of the greatest health care access issues facing vulnerable populations today. A study in the *Journal of the American Medical Association* found that primary care NPs are capable of providing high-quality care with comparable outcomes to primary care physicians (Mundinger et al., 2000). At the same time, data also indicate that nurse-managed health centers have higher rates of generic medication fills

and lower hospitalization rates than similar safety-net providers (National Nursing Centers Consortium [NNCC], 2007). The nurse-managed health center movement has the potential to bring high-quality, cost-effective primary care to more people than ever before. However, funding issues threaten the sustainability of this model of care. For example, 39% of the 70 grantees that received federal funding to establish nurse-managed health centers from 1993 to 2001 have closed. This figure provides stark evidence of the unique and major financial challenges that face nurse-managed health centers.

Like other primary care providers, NPs in nurse-managed health centers must navigate the complex and often uncoordinated landscape of MCO reimbursement and credentialing policies. Although approximately 40% of all patients seen in nurse-managed health centers are uninsured or self-pay, the remainder has either public or commercial insurance that could provide some reimbursement for the care provided in nurse-managed health centers. About one third of all nurse-managed health center patients are either Medicaid or Medicare beneficiaries. Twenty-eight percent of patients seen in nurse-managed health centers have commercial insurance coverage.

Although most nurse-managed health centers use a sliding fee structure to collect payments from uninsured patients, much of the cost of providing care to the uninsured goes uncompensated. As a result, many centers rely heavily on charitable grants from private foundations to remain operational. However, to achieve true financial sustainability, nurse-managed health centers must also receive fair reimbursement from insurance companies for the care that the centers provide to managed care enrollees every day. For these reasons, it is crucial that MCOs apply equitable credentialing and reimbursement policies to primary care NPs.

Method and Overall Findings

The survey target list was created using *HealthLeaders-Interstudy Competitive Edge Managed Care Directory* (HealthLeaders-InterStudy, 2006b). Researchers compiled a target contact list by determining the top 10 MCOs in each state (in terms of enrollment) offering HMO product lines. Using a defined protocol, surveyors contacted these leading MCOs in all 50 states and the District of Columbia via telephone during the course of 2 months in 2007 to request information about credentialing and reimbursement policies. Surveyors called MCOs' general phone numbers and asked to speak with staff in the plans' credentialing or contracting departments. In some cases, surveyors were directed by managed care

employees to speak with public relations representatives or managers at the insurer's regional or national headquarters.

In the case of national or regional companies with operations in multiple states, surveyors counted each state operation as a separate managed care plan despite the fact that many large managed care companies adopt uniform, companywide credentialing policies. This method of tabulation was selected to illustrate the true impact of managed care consolidation on providers in different states throughout the country.

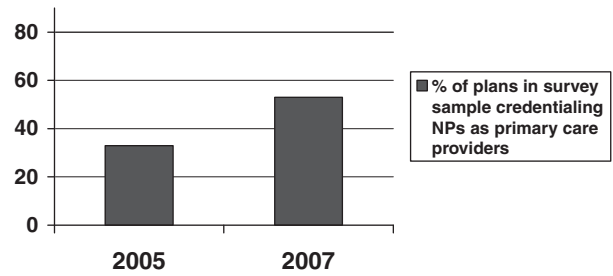
Surveyors contacted 336 MCOs during the course of this study. Of those, 222 plans elected to participate in at least one part of the survey (a 66% response rate). This figure represents a significant increase compared to the 2005 managed care survey (which had a 54% response rate), suggesting that managed care credentialing processes have become somewhat more transparent.¹ In the case of plans that were contacted but did not participate in the survey, surveyors contacted nurse-managed health center staff and managers to collect additional information about MCO contracting policies. Where possible, this supplemental information is incorporated in the final survey sample.

Overall findings regarding credentialing and reimbursement policies across the entire survey sample are illustrated in Figure 1. Compared to the 2005 survey, managed care credentialing policies regarding NP primary care providers have generally improved. In many categories, these improvements are quite substantial. For example, in 2005, only 33% of all companies surveyed credentialed NPs as primary care providers. In 2007, 53% of companies surveyed had instituted pro-NP credentialing policies. Although this progress is encouraging, there remains much work to be done, as nearly half of all MCOs surveyed in 2007 refuse to credential NPs as primary care providers.

Among managed care companies that credential NPs as primary care providers, 56% reimburse primary care NPs at the same rate as primary care physicians, and 38% reimburse NP primary care providers at a lower rate than primary care physicians. Six percent of plans surveyed reimburse primary care NPs at lower rates than primary care physicians but may make exceptions in areas experiencing physician shortages. Figure 2 illustrates these findings. These numbers represent a slight improvement over the results of the 2005 survey, where only 52% of plans surveyed reimbursed primary care NPs at the same rate as primary care physicians.

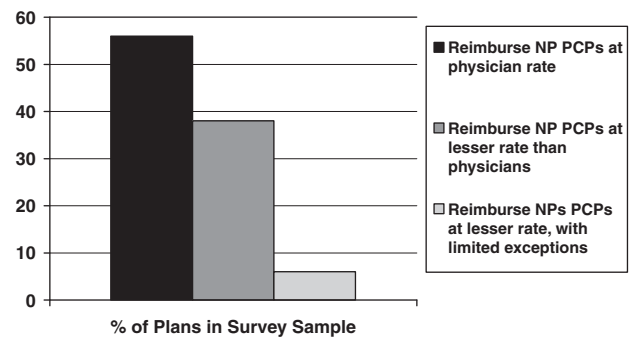
In cases where managed care staff indicated that the company did not credential NPs as primary care providers, surveyors asked the staff member why the

Figure 1
Comparison of Managed Care Credentialing Policies, 2005 to 2007



Note: NP = nurse practitioner.

Figure 2
Reimbursement Policies Among Health Maintenance Organizations Credentialing Nurse Practitioner (NP) Primary Care Providers (PCP), 2007



company had this policy. The most commonly stated reason for not credentialing NP primary care providers was that NPs must bill under a physician's provider number. Other stated reasons for not credentialing NP primary care providers included the following:

NPs are credentialed as primary care providers only in areas where there is a physician shortage.

NPs do not meet the company's criteria for primary care providers.

State law does not require the company to credential NPs as primary care providers.

The National Committee for Quality Assurance accreditation process prevents the company from credentialing NP primary care providers.²

This lack of uniformity among stated rationales for not credentialing NPs as primary care providers is similar to that found in the 2005 survey of managed care credentialing and reimbursement policies. As in 2005, managed

care staff in 2007 provided survey responses that demonstrated a lack of understanding of NPs' ability to provide comprehensive primary care services. A number of responses (including those indicating that NPs were not to be credentialed unless there was a physician shortage or unless insurers were compelled to do so by law) also suggest an implicit assumption among many insurers that NPs are primary care providers of last resort. These conclusions are bolstered by the survey's overall findings, which also demonstrate that many insurers still do not consider NPs to be the equal of physicians in their role as primary care provider.

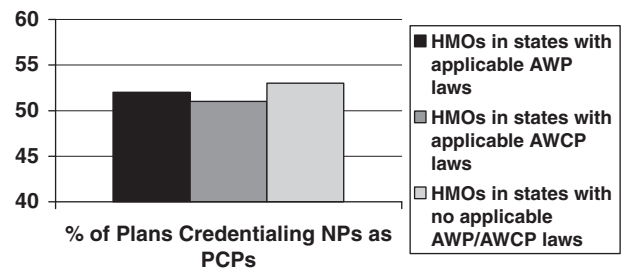
State Regulation of Managed Care Companies: Any Willing Provider and Any Willing Class of Provider Laws

A number of laws at the state and federal level are designed to prevent MCO discrimination against certain types of providers; however, survey results indicate that these laws do not protect primary care NPs from discriminatory MCO credentialing or reimbursement policies. Currently, 23 states have some form of "any willing provider" (AWP) law in effect. AWP laws ostensibly require MCOs to admit into their provider networks any willing provider able to meet the terms of the MCO's provider agreement. A number of these AWP laws explicitly apply only to providers such as dentists, optometrists, or chiropractors. Some others use broad, unspecific language to describe the types of providers that are covered by the law, and other AWP laws apply only to preferred provider organizations (PPOs) and not to the more prevalent HMO product lines.

Another related type of law meant to eliminate unfair discrimination against providers are "any willing class of provider" (AWCP) laws. These laws prohibit MCOs from refusing to contract with a particular provider solely because of the provider's licensure. AWCP laws are similar to AWP laws; however, they are often even more broad and unspecific than AWP laws and include significant qualifying language that limits their impact.

Many of these laws were passed by state legislatures in the 1990s (Carroll & Ambrose, 2002). In recent years, there have been no new AWCP laws passed by state legislatures and only one act regarding AWP laws.³ MCOs have consistently opposed the creation of these types of laws on the grounds that they increase the cost of providing insurance by preventing plans from creating exclusive provider networks (*Kentucky Association of Health Plans v. Miller*, 2003). As a result, many AWP and AWCP laws contain compromise language that

Figure 3
Correlation Between State Laws and HMO Credentialing Policies, 2007



Note: HMO = health maintenance organization; AWP = any willing provider; AWCP = any willing class of provider; NP = nurse practitioner; PCP = primary care provider.

significantly limits their power and scope (Hansen-Turton, Ritter, Rothman, & Valdez, 2006).

The significant limitations of these laws are indicated in the results of the 2007 survey, which indicate that state-level AWP and AWCP laws have no positive impact on managed care credentialing policies regarding NP primary care providers. Figure 3 illustrates this finding. In states with AWP laws that arguably apply to NPs seeking entrance into MCO provider networks, 52% of plans surveyed credential NPs as primary care providers. In states with AWCP laws that arguably apply to NPs seeking entrance into MCO provider networks, 51% of plans surveyed credential NPs as primary care providers. Meanwhile, 53% of plans in states with neither AWP nor AWCP laws credential NPs as primary care providers. In short, the statistics among each of the categories are nearly indistinguishable.

The results of this study are somewhat different, but are essentially in keeping with the results of the 2005 managed care survey conducted by the NNCC. In 2005, significantly fewer MCOs in all categories credentialed NPs as primary care providers; however, in 2005, AWP laws were found to have a slight correlation with improved credentialing policies regarding NP primary care providers. In 2005, as in 2007, there was also a complete lack of a positive correlation between AWCP laws and MCO policies regarding NP primary care providers.

Although it is somewhat encouraging that many MCOs have changed their policies in the past 2 years to allow more NPs to be credentialed as PCPs, the 2007 survey results suggest that state provider discrimination laws are not the source of this increase. With the possible exception of certain aspects of the amended AWP law in Arkansas, there is no substantive evidence that AWP or AWCP laws are more strictly enforced now than they

were in 2005 (HealthLeaders-Interstudy, 2006a). Furthermore, the fact that the statistics among each of the three categories in Figure 3 are essentially identical suggests that any increase in NP credentialing rates is a result of national trends and not the result of state anti-provider-discrimination laws.

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

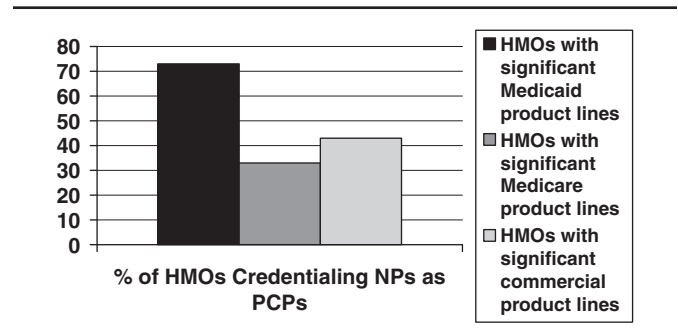
A large percentage of Medicaid and Medicare beneficiaries receive benefits through managed care plans. A 2006 report from the Centers for Medicaid and Medicare Services (CMS) indicates that 42 states have enrolled the majority of their Medicaid beneficiaries in a managed care plan (CMS, 2006). Enrollment in Medicare managed care plans (also known as Medicare Advantage plans) is less widespread but nevertheless significant. Nationally, 18.5% of all Medicare beneficiaries receive their benefits through a managed care plan (Henry J. Kaiser Family Foundation, 2006). However, some of the most heavily populated states in the country have higher-than-average Medicare managed care penetration. In addition, the penetration rates for both Medicaid and Medicare managed care plans have increased since 2005, indicating an increasing trend in managed care enrollment for beneficiaries of publicly funded health programs.

The federal government has created two regulations, similar to the AWCP laws that have been adopted by a number of state governments, that are applicable to Medicaid and Medicare Advantage managed care insurers. These regulations were drafted to prevent unfair discrimination against providers (Health Care Financing Administration, 2001). However, like AWCP laws at the state level, these federal regulations include language that significantly limits their scope and impact.

Since 2002, a regulation has been in effect that prohibits provider discrimination by MCOs participating in the Medicaid program. This regulation (found at 42 C.F.R. §438.12) states that an MCO "may not discriminate for the participation [or] reimbursement . . . of any provider who is acting within the scope of his or her license or certification . . . solely on the basis of that license or certification." A regulation with nearly identical wording, applicable to MCOs participating in the Medicare Advantage program, can be found at 42 C.F.R. §422.205.

The results of this survey suggest that federal regulations intended to eliminate unfair discrimination against nonphysician providers have no positive impact on the

Figure 4
Correlation of HMO Product Lines With Credentialing Policies, 2007



Note: HMO = health maintenance organization; NP = nurse practitioner; PCP = primary care provider.

credentialing policies of Medicaid and Medicare HMOs regarding NP primary care providers. Figure 4 illustrates these findings. HMOs with significant Medicaid product lines were much more likely than any other category of HMO in the entire survey to credential NPs as primary care providers (73% of HMOs surveyed in this category credential NPs as primary care providers). For the purposes of this study, an HMO was deemed to have a "significant" product line if greater than 30% of the HMO's total enrollees were enrolled under a particular product line category (i.e., Medicaid, Medicare, or commercial product line). Only 43% of HMOs with significant commercial product lines credentialed NP primary care providers, and only 33% of HMOs with significant Medicare product lines credentialed NP primary care providers.

These findings are similar to those found during the 2005 survey of managed care credentialing policies. In general, MCOs across all categories are more likely to credential NP primary care providers in 2007 than they were in 2005. However, the breakdown of credentialing rates among the different categories of MCO substantially mirrors the breakdown that was found in 2005. In 2005, 60% of Medicaid managed care plans credentialed NP primary care providers, 24% of commercial MCOs credentialed NP primary care providers, and 24% of Medicare managed care plans credentialed NP primary care providers.

It is worth noting that the plans that have made the biggest strides in NP credentialing practices are those in the commercial category. Since 2005, pro-NP credentialing policies have experienced a 19% jump among commercial plans. This strongly suggests that any increases in NP credentialing among Medicaid and Medicare plans in the past 2 years are not the result of increased enforcement of federal regulations but are instead the result of

larger economic trends that have affected MCOs in all categories.

In both 2005 and 2007, Medicaid managed care plans were found to be much more likely than plans in other categories to credential NPs as primary care providers. This may be because of the fact that Medicaid beneficiaries often have very limited access to primary care physicians. According to the Centers for Disease Control's (2007) *Morbidity and Mortality Weekly Report*, in 2007 nearly one third of all primary care physicians refuse to accept new patients who are expected to use Medicaid to pay for care. In some states, this percentage is significantly higher. For example, a 2007 survey conducted by the Massachusetts Medical Society found that 41% of primary care physicians in the state refused to accept Medicaid as a form of payment (Massachusetts Medical Society, 2007). In a climate such as this, Medicaid MCOs may be more likely to credential NP primary care providers because primary care physicians are becoming less and less accessible to Medicaid beneficiaries.

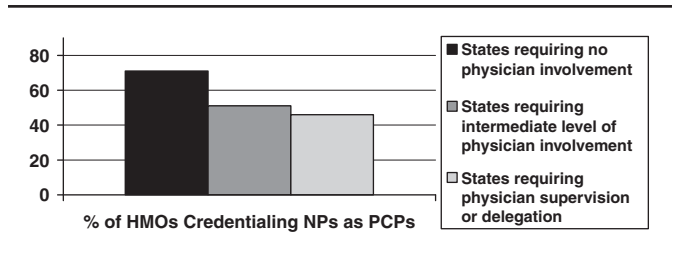
State Regulation of NPs: Physician Collaboration Requirements for Prescriptive Authority

Most NPs in the United States have a collaborative relationship with a physician to ensure quality care. In some states, NPs must be supervised by physicians to prescribe medication; in others, NPs may provide care and prescribe medication entirely independent of physician supervision. Although NPs' independence from physician involvement varies somewhat from state to state, NPs may prescribe medication in all 50 states and the District of Columbia.

In states that require no physician involvement for NPs to prescribe, 71% of HMOs surveyed credential NPs as primary care providers. State laws allowing NP prescriptive independence were one of the single strongest indicators (across the entire survey) of pro-NP credentialing policies.

In states that require more physician involvement for NP prescriptive power, fewer managed care companies are willing to credential NPs as primary care providers. In states that require physician collaboration (or some similar intermediate level of physician involvement) for NPs to prescribe, 50% of HMOs surveyed credential NPs as primary care providers. In states that require physician supervision or delegation for NPs to prescribe, only 46% of HMOs surveyed credential NPs as primary care providers. These results are illustrated in Figure 5.

Figure 5
Correlation Between State Requirements for NP Prescriptive Authority and HMO Credentialing Policies, 2007



Note: HMO = health maintenance organization; NP = nurse practitioner; PCP = primary care provider.

Although no managed care staff members told surveyors that their company's policies were based on state laws regarding NP prescriptive authority, there is a direct correlation between NPs' prescriptive independence and managed care credentialing policies. This correlation is somewhat less dramatic than it was in 2005 but compelling nevertheless. In 2005, surveyors found that 64% of managed care companies in states that allowed NPs to prescribe independently credentialed NPs as PCPs. In states that required physician delegation for NPs to prescribe, 0% of managed care plans surveyed in 2005 credentialed NPs as primary care providers.

The 2007 survey results show that significant progress has been made in terms of managed care policies regarding NP primary care providers, especially in states that require greater physician involvement for NP prescriptive authority. However, the 2007 survey also shows that there continues to be a direct correlation between NP prescriptive independence and managed care credentialing policies.

Conclusion

The NNCC's 2007 update of its managed care credentialing and reimbursement study demonstrates that managed care companies have made some progress in adopting NP-friendly credentialing and reimbursement policies. However, the results of this survey also suggest that this progress is not because of increased enforcement of anti-provider-discrimination laws but is instead the result of larger economic trends and trends in the health care system as a whole.

This survey update revealed that great strides have been made among plans offering commercial products with regard to credentialing policies. It also showed that

Medicaid plans are more likely to credential primary care NPs than plans in any other category studied. When combined with other survey results showing the general ineffectiveness of state and federal anti-provider-discrimination laws, these results strongly suggest that any improvement in NP credentialing policies is because of nonregulatory changes in the health care industry and not the enforcement of existing laws. As noted above, improved Medicaid credentialing policies regarding NPs may be linked to primary care physicians' growing refusal to provide care to Medicaid beneficiaries. Meanwhile, the increase in pro-NP credentialing policies among commercial plans may potentially be linked to the nationwide increase in the number of NP-staffed retail-based health clinics (Hansen-Turton, Ryan, Miller, Counts, & Nash, 2007). For example, it is possible that the excitement, controversy, and increase in media attention surrounding these new clinics may have led insurers to develop a better, broader understanding of NPs' clinical capabilities. Although researchers believe that these are credible explanations for such findings, further research is required to fully determine the reasons for markedly improved credentialing policies among commercial insurers and Medicaid insurers.

Despite increases in the number of NPs who have been able to secure better credentialing status and reimbursement, the goal of obtaining widespread, uniform, equitable credentialing and reimbursement for NP primary care providers will remain elusive as long as laws forbidding provider discrimination are not enforced and as long as managed care companies view NPs as primary care providers of last resort. For nurse-managed health centers to continue to provide primary health care services in areas where physician access is limited, primary care 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 educate MCO staff and remove financial barriers to nurse-managed health center practice.

Two years later, MCOs continue to hold the key to equitable treatment for primary care NPs. The increased use of NPs has the significant potential to reduce both health care spending levels and health disparities at a time when the nation is searching for innovative ways to address a looming primary care crisis. However, as long as payers undervalue their contributions, NPs will not meet their full potential, and underserved communities will feel the impact. By ensuring equitable treatment for NP primary care providers in nurse-managed health centers, we can also ensure the sustainability of an important component of the nation's health care safety net.

Notes

1. In general, managed care staff was considerably more willing to answer questions about credentialing policies. The response rate when surveyors requested additional information about reimbursement rates for nurse practitioner (NP) primary care providers was somewhat lower, as many managed care companies consider such information proprietary.

2. The authors suggest that the nursing community work with the National Committee for Quality Assurance (NCQA) and insurers to clarify this issue. Multiple insurers with an *excellent* rating from NCQA responded to the survey with information indicating that they credential NPs as primary care providers (through either a planwide policy or a special policy for underserved areas), suggesting that it is a misunderstanding of NCQA standards to conclude that they require companies to adopt a uniform policy prohibiting the credentialing of NPs as primary care providers.

3. In 2005, the Arkansas state legislature acted to clarify the application of its existing "any willing provider" (AWP) law in the face of a court opinion by the Eighth Circuit Court of Appeals. Since the mid-1990s, no additional states have adopted new AWP or "any willing class of provider" laws.

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