

# Improving access to healthcare one state at a time

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Abstract: The Annual Legislative Update describes recent legislative changes to practice, reimbursement, and prescriptive authority that have the most impact on NPs and other advanced practice nurses across the country.

n 2017, over 20 states passed legislation that positively impacted access to and delivery of healthcare to patients nationwide. As in previous years, professional advanced practice registered nurse (APRN) organizations and Boards of Nursing (BONs) have worked tirelessly in their respective legislative sessions to ensure patients have access to highquality healthcare services in their states. Following is a summary of legislative advancements pertaining to practice authority, reimbursement, and prescriptive authority in 2017.

Keywords: advanced practice registered nurses, APRNs, healthcare reform, legislative update, nurse practitioners

Two states in particular are highlighted for their substantial and successful efforts in moving toward full-practice authority. Lawmakers have recognized the importance of APRN practice and their impact on access to and delivery of high-quality healthcare in **South Dakota** and **Illinois**. These states join a growing list of states that have passed full-practice authority (FPA) with and without exceptions following a period of supervision, collaboration, or consultation with an APRN and/or physician following licensure since enactment of the Patient Protection and Affordable Care Act in 2010 (see *Summary of practice authority for NPs*).

On September 20, 2017, **Illinois** enacted Public Act 100-0513, extending FPA to APRNs after attaining national certification and following a transition to practice period, including 250 hours of continuing education or training and 4,000 hours of clinical experience in collaboration with a physician. The definition of FPA in Illinois *excludes* authority to prescribe benzodiazepines and Schedule II controlled substance narcotic medications. APRNs must maintain a consultation relationship with a physician if these medications will be prescribed by an APRN; the relationship must be recorded in a Prescription Drug Monitoring Program (PDMP) by the physician and APRN.

The transition to practice period and exclusion of benzodiazepines and Schedule II controlled substance narcotic medications within the FPA definition does

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not apply to an APRN when privileged to practice in a hospital, hospital affiliate, or ambulatory surgical treatment center. Although the statutory definition for FPA does not meet the standard for full practice according to the AANP¹, the state's sponsoring legislators and APRNs feel the positive impact this new authority will have on access to care outweighs the narrow area of practice where physician consultation is still a requirement.

On February 23, 2017, **South Dakota's** governor signed Senate Bill 61 into law, removing the requirement of a collaborative agreement and thereby adopting FPA for certified nurse practitioners (CNPs) and certified nurse midwives (CNMs) after verified

completion of 1,040 hours of practice in collaboration with a physician, CNP, or CNM. The BON now solely regulates both CNPs and CNMs, and FPA includes prescriptive authority for legend and scheduled controlled substances, without exception, identifying South Dakota as full practice by the AANP. Please see the individual state descriptions for additional information.

#### Practice authority

Major accomplishments in the area of practice authority for NPs during the 2017 legislative session included the passage of global and partial signature authority, recommendation for medical marijuana use, adoption of the APRN Consensus Model recommendations on APRN role recognition and educational programs, as well as clarification on ownership of medical corporations and minor surgical procedure authorization.

Signature authority. Six states enacted legislation pertaining to full or partial global and partial signature recognition and authority, including APRN authorization for certain aspects of care. Global signature authority is generally defined as authorization for recognized APRNs to sign, certify, or endorse all documents related to healthcare within their scope of practice (SOP) provided for their patients. Some states limit these documents (partial) to a statutorily authorized list, while others are broader in their approach.

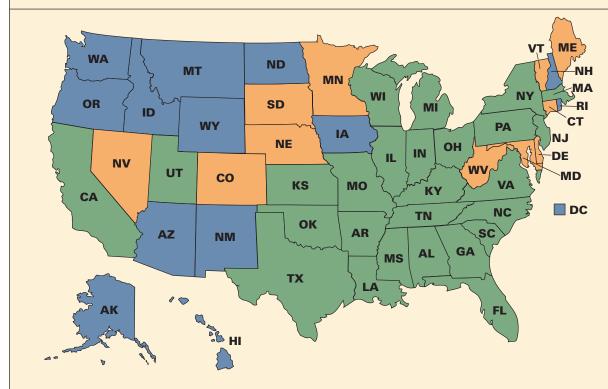
APRN authority to sign death certificates among other documents is particularly important and was accomplished in **Arkansas** (Act 372; enacted March 2017), **Minnesota** (HF 2177; effective May 2017), **Nevada** (Chapter 318; effective

January 2018), **Texas** (SB 919; effective June 2017), and **Wyoming** (Chapter 160; effective March 2017). **North Carolina** (Act 2017-111; effective July 2017) enacted legislation adding NPs to the list of providers authorized to sign handicap parking certificates.

Recommendation for medical marijuana use. The **District of Columbia** joins Connecticut, Hawaii, Maryland, Maine, and New York as states/districts that authorize APRNs as providers who may recommend the use of medical marijuana to a qualifying patient with a qualifying medical condition as described. Act 21-565, Medical Marijuana Omnibus Amendment Act of 2016, was issued December 16, 2016. This authority does not confer prescriptive

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#### **Summary of Practice Authority for NPs**



#### **Full Practice**

NPs are regulated by a BON and have full, autonomous practice and prescriptive authority without a requirement or attestation for physician supervision, delegation, consultation, or collaboration: AK, AZ, DC, HI, IA, ID, MT, ND, NH, NM, OR, RI, WA, WY

[Washington, D.C. is included as a state in this table.]

#### **Full Practice or Reduced Practice** with Transition

NPs are regulated by a BON and have full autonomous practice and prescriptive authority but require a postlicensure/certification period of supervision, collaboration, or mentorship: CO\*, CT, DE\*, MD\*, ME\*, MN\*, NE, NV\*, SD\*, VT\*, WV^\*

#### **Reduced or Restricted Practice**

NPs are regulated by a BON or a combination of BON and BOM oversight exists; requirement or attestation for physician supervision, delegation, consultation, or collaboration for authority to practice and/or prescriptive authority: AL, AR, CA, FL, GA, IL<sup>+</sup>, IN, KS, KY, LA, MA, MI, MO, MS, NC, NJ, NY, OH, OK, PA, SC, TN, TX, UT, VA, WI

- CO: 1,000-hour post-licensure practice period
- CT: 3-year and a minimum of 2,000-hour post-licensure practice period
- DE: 2-year and a minimum of 4,000-fulltime-hour post-licensure period
- MD: 18-month post-licensure practice period
- ME: 24-month post-licensure practice period
- MN: 2,080-hour post-licensure practice period
- NE: 2,000-hour post-licensure practice period
- NV: 2-year or 2,000-hour post-licensure practice period
- SD: 1,040-hour post-licensure practice period
- VT: 2-year and 2,400-hour post-licensure practice period
- NY: 3,600-hour post-licensure practice period and attestation of physician collaboration required

IL: 4,000-hour post-licensure practice period + 250 continuing education/ training units; Controlled substances Schedule II opioids and benzodiazepine prescribing requires physician consultation

† APRNs credentialed in a hospital, hospital affiliate, or ambulatorysurgical treatment center may practice without a written collaboration

WV: 3-year post-licensure practice period; ^Excludes Schedules I, II controlled substances, antineoplastics, radiopharmaceuticals, and general

State may not require post-licensure/certification period of supervision, collaboration, or mentorship when an experienced NP endorsing into the state has met the regulatory requirement through experience in another state

authority as marijuana is listed as a Schedule I controlled substance by the Drug Enforcement Administration (DEA). Designated APRNs in these states have authority to recommend the use of this substance as described by each state's law.

Consensus Model adoption. The Legislative Update has provided readers with annual progress on implementation of Consensus Model adoption. According to the National Council of State Boards of Nursing, 15 states have implemented 100% of the Consensus Model recommendations for APRN licensure, accreditation of APRN programs, certification in respective APRN roles, and educational program requirements.<sup>2</sup> Although many states have achieved FPA as defined by the AANP, many states continue to work on legislative and regulatory amendments to move toward uniformity in these areas.

The enactment of **Michigan**'s Public Act 499 of 2016 recognizes the clinical nurse specialists (CNS) as an APRN role and adds a CNS seat to the Michigan BON. Additionally, the act defines APRN in statute, recognizing nurse midwives, NPs, and CNSs as APRNs. **Minnesota** amended their law requiring APRN programs to include separate, graduate-level courses in advanced physiology and pathophysiology, advanced health assessment, and pharmacokinetics/pharmacodynamics of all broad categories of agents in alignment with the Consensus Model recommendations.

North Dakota adopted the APRN Compact for licensure in 2017, joining Wyoming and Idaho as the third APRN licensure compact state in the United States. The purpose of the APRN Compact is to provide opportunities for interstate practice by APRNs who meet uniform licensure requirements, facilitation of information exchange between compact states in areas of APRN regulation, investigation, and adverse actions, among other things.<sup>3</sup> Oklahoma updated statutes to reflect the recommended title "APRN" from advanced practice nurse (APN) throughout the Nurse Practice Act.

Ordering home health services. This year, survey respondents were asked to respond to a question regarding state statutory authority to order home health services. If the home health agency is Medicare- and/ or Medicaid-certified, 42 Code of Federal Regulation 484.18 (c) requires a physician signature to order home health services. However, some states authorize home health agencies to accept orders from APRNs when patients are private-paying or non-Medicare/ non-Medicaid recipients under state law. While many states did not respond to the question, there is initial

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State statutory authority	CA, FL, OR, WY
Statutory authority not prohibited	CO, NH
No statutory authority	KS, RI, SD, VA, WV

information on statutory authority (see *State response to statutory/regulatory authority*).

Advances in protocol/collaborative agreement requirements and SOP. Florida successfully removed the requirement to file ARNP protocols with the BON. Effective June 23, 2017, ARNP protocols must be maintained onsite at the practice location. The supervisory nature of practice in Florida was not changed during this legislative session. Oregon amended ORS 435.305, which previously prohibited performance of a sterilization procedure by an NP. NPs are now authorized to perform a vasectomy, specifically citing the procedure is within the NP's SOP.

Professional corporations. **Oregon** amended current law, authorizing co-ownership of medical clinics by NPs, physicians, and physician assistants (PAs). Specifically, the corporations' codes were amended to clarify that the majority of directors and shareholders of a medical corporation can be physicians, NPs, or PAs. The law specifically prohibits a physician, NP, or PA from directing the services of another practitioner in the professional corporation unless the other practitioner also practices within the same SOP. Additionally, individuals employed in the professional corporation or individuals who own interest in the corporation may not direct medical judgment of the physician, NP, or PA. This law will go into effect January 1, 2018.

#### Reimbursement

Amendments to statutes or regulations pertaining to APRN reimbursement historically have been lacking. In 2017, only one state reported the passage of legislation impacting APRN reimbursement. On June 7, 2017, **Vermont** enacted Act 64 relating to insurance coverage for telemedicine services delivered in or outside a healthcare facility. Specifically, Act 64 requires commercial health plans and Medicaid to cover telemedicine services regardless of where the patient receives those services. The act uses the provider-neutral term "healthcare provider," inclusive of APRNs as providers for whom the plan must provide reimbursement.

#### Prescriptive authority

Controlled substances regulation. In July 2017, Alaska enacted Chapter 2 SSLA 17, mandating PDMP registration by all DEA registered prescribers licensed in the state of Alaska. Practitioners must review PDMP

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#### Total Number of Licensed/Certified APRNs Reported by BONs and/or State Nursing Associations in 2017

State	NPs	CNSs	CNMs	CRNAs	Total APRNs
Alabama	3,993	78	14	1,696	5,781
Alaska	*	*	*	*	1,004
Arizona	6,787	177	258	835	8,057
Arkansas∞	1,660	138	25	559	2,382
California	23,658	3,505	1,289	2,405	30,857
Colorado	4,926	599	432	872	6,829
Connecticut∞	*	*	!	*	4,439
Delaware∞	954	179	41	343	1,517
District of Columbia	1,837	60	128	198	2,223
Florida	*	206!	*	*	25,180
Georgia	9,684	383	533	1,914	12,514
Hawaii∞	*	*	*	*	1,360
Idaho	1,411	48	69	524	2,052
Illinois	9,507	1,034	511	2,009	13,061
Indiana∞	*	*	*	1	3,989
lowa	3,216	76	127	601	4,020
Kansas	3,522	542	78	1,025	5,167
Kentucky	5,873	176	132	1,389	7,570
Louisiana	3,724	160	49	1,451	5,384
Maine	1,634	81	101	444	2,260
Maryland	4,782	115	256	782	5,935
Massachusetts	8,675	41 CNS; 809 PCNS	502	1,307	11,334
	5,985	41 CN3, 809 FCN3	348	2,583	
Michigan∞		!			8,916
Minnesota	5,139	531	329	2,016	8,015
Mississippi∞	2,721	Not reported	33	734	3,488
Missouri	7,162	366	127	1,802	9,457
Montana	1,021	38	59	162	1,280
Nebraska∞	1,474	88	45	541	2,148
Nevada∞	1,451	*	*	144*	1,595
New Hampshire∞	1,546	@	105	313	1,964
New Jersey	*	*	! (BOME)	*	8,930
New Mexico	2,022	123	208!	441	2,586
New York	23,948	!	!	!	23,948
North Carolina	7,155	246	321	3,085	10,807
North Dakota	953	48	17	393	1,411
Ohio	11,622	1,558	397	3,183	16,760
Oklahoma	2,517	277	65	713	3,572
Oregon	4,048	202	#352	647	4,897
Pennsylvania∞	10,737	222	!	!	10,959
Rhode Island	1,050	143	75!	231	1,424
South Carolina∞	1,797	43	105	1,352	3,297
South Dakota	901	67	36	458	1,462
Tennessee	9,442	136	188	2,549	12,315
Texas	18,851	1,322	480	4,565	25,218
Utah∞		2,042	160	273	2,475
Vermont∞	630	39@	74	69	812
Virginia	*	437††	*	*	8,824
Washington	5,556	39	460	1,438	7,493
West Virginia	1,899	30	59	761	2,749
Wisconsin∞	+	+	+	+	3,875+
Wyoming	552	11	24	137	724
Totals	226,022§	14,373§	8,612§	46,944§	354,062

<sup>\*</sup> Combined with total number of APNs/APRNs for that state; these states may not break out NP, CNS, CNM,or CRNA numbers individually TRecognized as APRNs but counted separately from other APRN roles
! Not recognized as an APN/APRN/ARNP by the BON and not included in total APRNs
@ Psychiatric clinical nurse specialists recognized as APRNs only
Licensed/certified as NPs by the BON
+ Certified as APNPs (Advanced Practice Nurse Prescribers)

No update to APRN license/certification number was provided by BON.

Total of the states that breakout NP, CNS, CNM, or CRNA numbers individually

information prior to prescribing or administering a Schedule II or III controlled substance with certain exceptions, including those receiving treatment in an inpatient setting; at the scene of an emergency; in an ED; immediately before, during, or within 48 hours after surgery or medical procedure; in a hospice or long-term-care facility that has an in-house pharmacy; or when a nonrefillable prescription of a controlled substance in a quantity for no longer than 3 days. Adambulatory settings by NPs and PAs. NPs and PAs seeking this authority must complete a required 24hour training course related to medication-assisted treatment of substance abuse disorder prior to applying to the DEA for a waiver. This year, California passed legislation codifying federal authority, eliminating confusion of authority with the DEA when an NP applies for a buprenorphine waiver. This law will go into effect January 1, 2018. Oregon reported

NPs are authorized to prescribe buprenorphine under federal law.

Miscellaneous updates to existing prescriptive authority statutes. As state APRN and nursing organizations and BONs work toward FPA, incremental advances provide the

opportunity to improve access over time. Tennessee made substantive change in terminology surrounding the professional relationship between physicians and APRNs for prescriptive services, amending code sections utilizing "supervision" to "collaboration." Designated responsibilities and relationships between physicians and APRNs were not altered through this legislation; however, changes such as this inform the public about the nature of the relationship between APRNs and physicians in individual states.

The author would like to thank the state BON representatives and APRN association representatives who contributed to this update via submission of the annual survey. All efforts are made to ensure the information provided to readers is accurate and up-todate through validation of adopted regulations and enacted legislation.



Vermont enacted Act 64 relating to insurance coverage for telemedicine services delivered in or outside a healthcare facility.

ditionally, APRNs are required to complete at least 2 hours of continuing education in opioid prescribing each license renewal period.

Kentucky, Louisiana, and North Carolina have adopted statutes limiting the quantity of initial and/ or refill prescriptions of opioid controlled substances. Reacting to the nation's opioid misuse crisis, states are increasingly regulating all prescribers with respect to opioid medications with reasonable exception. The publication of the CDC's Guideline for Prescribing Opioids for Chronic Pain in 2016 has provided lawmakers with evidence needed to positively impact the use of opioids for pain conditions.4

Kentucky amended KRS 218A.205, establishing mandatory prescribing and dispensing standards related to controlled substances in Schedules II and III for the purpose of treating acute and chronic pain in accord with the CDC's guidelines.4 Louisiana approved Act 82 in August 2017, limiting the number of days opioids can be prescribed with some exceptions. North Carolina adopted the Strengthen Opioid Misuse Prevention (STOP) Act, CH. SL 2017.74, applying provisions for screening and prescribing of targeted controlled substances, including limits on the length of initial and refill prescriptions of opioid medications for acute pain with some exceptions. The statute requires NPs to consult with a supervising physician prior to prescribing a targeted controlled substance under certain conditions.

Comprehensive Addiction and Recovery Act (CARA). Signed into federal law in July 2016, CARA expanded access to substance use treatment services by extending the privilege of prescribing buprenorphine in

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# Alabama

www.npalliancealabama.org www.abn.alabama.gov

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#### Legal authority

APRNs are defined as APNs in Alabama and include CNP (CRNP in statute), CNS, CNM, and CRNA roles. Although the BON has sole authority to establish the qualifications and certification requirements of APNs through R&Rs, the BON and BOME regulate the collaborative practice of physicians with CRNPs and CNMs, requiring them to practice with BON- and BOME-collaborative practice agreements. The collaborating physician and CRNP or CNM must sign written protocols. The term collaboration does not require direct, on-site supervision by the collaborating physician. The term does, however, require such professional oversight and direction as may be required by the R&R of the BON and BOME.

The CRNP or CNM and collaborating physician shall be present in any approved practice site a minimum of 10% of the CRNP/ CNM's scheduled hours if the CRNP or CNM has less than 2 years of collaborative practice experience. Remote practice site is defined in rule, and the collaborating physician must visit each remote site at least quarterly. CRNP SOP is defined in statute and regulation; APNs practice in accordance with national standards and functions identified by the appropriate specialty-certifying agency in congruence with Alabama law.

Alabama does not recognize APNs as PCPs and does not have "any willing provider" language in statute. CRNPs are required to hold an MSN degree and national certification upon entry into practice with a few exceptions: Initial CRNP applicants are exempt from requirement for MSN at the

discretion of the BON if graduation was before 1996 in a post-BSN NP program or graduation before 1984 from a non-BSN program preparing NPs.

CRNAs must, at minimum, hold a master's degree from an accredited nurse anesthesia graduate program and be currently certified as a CRNA; CRNAs who graduated before December 31, 2003, are exempt from the master's degree requirement. CNS approval requires a master's degree or higher in advanced practice nursing as a CNS and national certification.

#### Reimbursement

There are no legislative restrictions for APNs on managed-care panels. The Alabama Medicaid Program enrolls and reimburses CRNPs independently pursuant to supervision rules; however, a CRNP who is employed and reimbursed by a facility that receives reimbursement from the Alahama Medicaid program for services provided by the CRNP may not enroll. BC/BS will reimburse CRNPs and CNMs in collaboration with a preferred physician provider at 70% of the physician rate.

#### Prescriptive authority

CRNPs and CNMs may prescribe, administer, and provide therapeutic tests and drugs within a BON- and BOME-approved formulary. CRNPs and CNMs in collaborative practice with a physician may prescribe controlled substances in Schedules III, IV, and V pursuant to the rules of the Alabama BOME Chapter 540-X-18. CRNPs and CNMs are required to complete 12 continuing medical education contact hours in advanced pharmacology and prescribing trends and 4 additional contact hours every 2 years for renewal of the Qualified Alabama Controlled Substances Certificate under current regulation for Schedule III-V controlled substance authority.

A BON and BOME joint committee recommends R&R governing the collaborative relationship between physicians, CRNPs, CNMs, and the prescription of legend drugs that may be prescribed by authorized CRNPs and CNMs. Authorization is tied to the collaborative agreement; if CRNPs or CNMs change physicians, they must reapply. Prescription pads must include the physician's name and address, the CRNP's or CNM's name, RN license number, and prescription number. The CRNP or CNM who is in collaborative practice and has prescription privileges may sign for and dispense approved formulary drugs. CNSs and CRNAs are not regulated by the joint committee (BON and BOME) and are not eligible for Rx authority.

### Alaska

www.commerce.alaska.gov/web/cbpl/ professionallicensing/boardofnursing.aspx https://anpa.enpnetwork.com www.campaignforaction.org/state/alaska

#### Legal authority

APRNs are regulated by the Alaska BON, defined in statute, and include CNP, CNS, CNM, and CRNA roles. APRNs are further defined as RNs who, due to specialized education and experience, are certified to perform acts of medical diagnosis and prescription as well as dispense medical, therapeutic, or corrective measures under regulations adopted by the BON.

Regulations require that an APRN must have a plan for patient consultation and referral, but a physician relationship is not required. SOP for APRNs is not directly defined in statute or regulation; however, regulation refers to the national certifying body for definition of SOP in specialty areas.

#### Legislative update key

ANP Advanced Nurse Practitioner

**APN** Advanced Practice Nurse

**APNP** Advanced Practice Nurse Prescribers

APRN Advanced Practice Registered Nurse

ARNP Advanced Registered Nurse Practitioner

**ASTC** Ambulatory Surgical Treatment Center

**BC/BS** Blue Cross/Blue Shield

**BOM** Board of Medicine

**BOME** Board of Medical Examiners

BON Board of Nursing **BOP** Board of Pharmacy

**BRN** Board of Registered Nursing

CHAMPUS Civilian Health and Medical Program of the Uniformed Service CNM Certified Nurse Midwife

**CNP** Certified Nurse Practitioner

CNS Clinical Nurse Specialist

CPA Collaborative Practice Agreement

**CPNP** Certified Pediatric Nurse Practitioner

CRNA Certified Registered Nurse Anesthetist

**CRNP** Certified Registered Nurse Practitioner

**DEA** Drug Enforcement Administration

**DO** Doctor of Osteopathic Medicine **DPW** Department of Public Welfare

FNP Family Nurse Practitioner

FPA Full Practice Authority

**GNP** Geriatric Nurse Practitioner

HMO Health Maintenance Organization

MCOs Managed-care organizations

NA Nurse Anesthetist

NCSBN National Council of State Boards of Nursing

NM Nurse Midwife

NPA Nurse Practice Act

PA Physician Assistant

PCP Primary Care Provider

PCNS Psychiatric Clinical Nurse Specialist

PMH Psychiatric Mental Health

PNP Pediatric Nurse Practitioner

PPO Preferred Provider Organization RNP Registered Nurse Practitioner

**R&R** Rules and Regulations

Rx Prescriptive/Prescribe SOP Scope of Practice

WHNP Women's Health Nurse Practitioner

APRNs in Alaska are statutorily recognized as PCPs. Nothing in the law precludes admitting privileges for APRNs. Entry into APRN practice requires a graduate degree in nursing and national board certification. CE requirements for APRNs are 30 CE units; 12 of these must be advanced pharmacotherapeutics as well as 12 hours of CE in clinical management of patients every 2 years. CRNAs practice under separate BON rules and regulations from the CNP, CNS, and CNM; however, incorporation of all APRN regulations is in process.

#### Reimbursement

All healthcare in Alaska is provided on a fee-for-service basis, and managed care does not exist. FNPs, PNPs, and CNMs are authorized by law to receive Medicaid reimbursement; NPs receive 85% of the physician payment. A nondiscriminatory clause in the insurance law allows for third-party reimbursement to NPs; Alaska legally requires insurance companies to credential, empanel, and/or recognize APRNs. Alaska does not have "any willing provider" language in current law.

#### Prescriptive authority

Authorized APRNs have independent Rx authority—including Schedules II-V controlled substances—and may apply for DEA registration. APRNs are legally required to review the Prescription Drug Monitoring Program database prior to prescribing controlled substances. They are legally authorized to request, receive, and dispense pharmaceutical samples in Alaska. Prescriptions are labeled with the APRN's name only. To renew Rx authority, APRNs must complete 12 contact hours of continuing education (CE) in advanced pharmacotherapeutics, including 2 CE hours in opioid prescribing each 2-year renewal cycle.

### Arizona

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#### Legal authority

The Arizona State Legislature grants APRNs authority, and the BON alone regulates their practice. APRNs include RNPs, CNSs, CNMs, and CRNA roles. According to Arizona Revised Statutes Title 32, Chapter 15 32-1601; 20 (vi), the following language was added to both the RNP and the CNM definition:

...recognizing the limits of the nurse's knowledge and experience by consulting with or referring patients to other appropriate healthcare professionals if a situation or

condition occurs that is beyond the knowledge and experience of the nurse or if the referral will protect the health and welfare of the patient.

No formal collaboration agreement is required. RNP SOP is defined in the Arizona Administrative Code R4-19-508. In the SOP, RNPs are authorized to admit patients to healthcare facilities, manage the care of patients admitted, and discharge patients.

However, Arizona Department of Health regulations require that patients admitted to an acute care facility must have an attending physician. Acute care facilities apply this citation as the basis to deny independent admitting and hospital privileges to RNPs. RNPs, CNMs, and CNSs must have a graduate degree in nursing and national board certification in their focus area to enter into practice. CRNAs must have a graduate degree associated with an accredited CRNA program and hold national certification to enter into practice. For CRNA SOP, it was clarified that a physician or surgeon is not liable for any act or omission of a CRNA who orders or administers anesthetics. CRNAs, therefore, are responsible for their own practice.

#### Reimbursement

RNPs and other APRNs may receive third-party reimbursement, enabled by the Department of Insurance statutes. RNP reimbursement varies depending on the health insurance plan.

#### Prescriptive authority

RNPs have full Rx and dispensing authority, including controlled substances Schedules II-V, on application, and fulfillment of BON-established criteria. RNP Rx and dispensing authority is linked to the RNP's area of population focus and certification. For example, women's health RNPs are not authorized to prescribe medication to males except in cases of partner therapy for sexually transmitted infections (STIs). Prescribing without documenting an assessment is a violation of the NPA.

An RNP with Rx and dispensing authority who wishes to prescribe a controlled substance must apply to the DEA for a registration number and submit this number to the BON and the BOP. Drugs (other than controlled substances) may be refilled up to 1 year. The passage of ARS 36-2606 (effective 12/31/2015) requires RNPs who intend to hold or already hold a DEA registration number to also hold Controlled Substances Prescription Monitoring Program (CSPMP) registration issued by the BOP.

Effective October 1, 2017, prescribers must obtain a patient utilization report from the CSPMP's central database prior to prescribing an opioid analgesic or

benzodiazepine-controlled substances in Schedules II, III, or IV (with certain exceptions). Language has been added to the SOP for CRNAs to clarify that CRNAs may administer anesthetics and issue medication orders for medications, including controlled substances, to be administered by a licensed, certified, or registered health-care provider preoperatively, postoperatively, or as part of a procedure; CRNAs are not authorized to prescribe or dispense medications for patients to use outside of the CRNA's practice setting. CNSs do not have Rx authority in Arizona.

### Arkansas

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#### Legal authority

The BON grants APRNs authority to practice per an additional license separate from RN licensure. APRNs include CNP, CNM, CNS, and CRNA roles, which practice independently with the exception of RNPs (NPs who do not hold national certification). In this instance, RNPs must practice under physician direction/protocol and may only transcribe orders from a protocol.

The BON ceased issuing new RNP licenses in 1996. All NPs licensed after 1996 hold CNP licensure. Hospital privileges for APRNs are determined on a hospital-to-hospital basis according to the credentialing committee of each hospital. Graduate- or postgraduate-level APRN education and national board certification are required for initial APRN licensure. Current national certification must be maintained to continue to hold an APRN license.

#### ■ Reimbursement

The NPA mandates direct Medicaid reimbursement to APRNs and RNPs. Medicaid reimbursement is 80% of the physician rate. APRNs are not recognized as PCPs for Medicaid. A statutory provision exists for third-party reimbursement for CRNAs.

#### Prescriptive authority

The NPA authorizes the BON to provide a certificate of Rx authority to qualified APRNs. A collaborative practice agreement with a practicing physician (who has training in scope, specialty, or expertise to that of the APRN and use of Rx protocols) is required. APRNs with Rx authority may apply for and hold a DEA number. The NPA limits the prescribing of controlled substances to Schedules III-V and hydrocodone-combination products from Schedule II of the Controlled

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Substance Act (with authorization from the physician on the collaborative practice agreement). Neither protocols nor collaborative practice agreements with a physician are required unless the APRN has Rx authority.

Under the Chapter 4 Rules, an initial applicant for Rx authority must hold an active APRN license with completion of pharmacology course work of 3 graduate credit hours or 45 contact hours in a competency-tested pharmacology course; have 300 hours of precepted prescribing experience; and include a collaborative practice agreement with a physician.

Endorsement applicants must provide prescribing evidence of at least 500 hours in the last year and have a clear DEA history. APRNs who have fulfilled requirements for Rx authority may receive pharmaceutical samples and therapeutic devices appropriate to their area of practice. APRNs with Rx authority have implied authority to give Rx drug samples to patients.

### California

www.rn.ca.gov www.canpweb.org

www.campaignforaction.org/state/california

#### Legal authority

The California BRN grants legal authority to practice and regulates/issues separate certification to APRNs. Defined in statute, APRN includes CNP (NP in statute), CNM, CRNA, and CNS roles. NPs function under "standardized procedures" or protocols when performing medical functions, collaboratively developed and approved by the NP, physician, and administration in the organized healthcare facility in which they work.

NP SOP is defined within the standardized procedures commensurate with the NP's education and training, not in statute or regulation. CNPs and CNMs are statutorily recognized as PCPs in California's Medi-Cal system (Medicaid). APRNs are not legally authorized to admit patients to the hospital; however, individual hospitals may grant APRNs hospital privileges. CNPs and CNSs must hold a minimum of a master's degree in nursing or health-related field to practice; however, California does not require national certification to enter into practice. CRNAs are required to hold national certification to practice in the state of California.

#### Reimbursement

All nationally board-certified CNPs are reimbursed independently by the Medi-Cal system. Medi-Cal-covered services performed by CNPs, CNMs, and CRNAs are reimbursed at 100% of the physician

reimbursement rate. Blue Cross of CA Medi-Cal Provider Directory lists CNPs as PCPs under their specialty. There is no legal preclusion to third-party reimbursement of services, and policies vary from payer to payer; however, third-party payers are legally required to reimburse CNMs and BRN-listed psychiatric-mental health nurses for qualifying services. Participants in the state's managed-care programs for specified Medi-Cal beneficiaries may select CNPs and CNMs as their PCPs.

#### Prescriptive authority

CNPs and CNMs may "furnish," or order drugs or devices, including controlled substances II-V when the drugs or devices are furnished by a CNP or CNM in accordance with a standardized procedure and when separate authorization is granted by the BRN. Legislation passed in 2017 codifies in California law federal authority for NPs to furnish or order buprenorphine when done in compliance with the provisions of the Comprehensive Addiction Recovery Act (Public Law 114-198).

The act of "furnishing" is legally the same as prescribing and requires physician supervision of the CNP and CNM; however, the physician's physical presence is not required. Prescriptions are labeled with the CNP's or CNM's name only. CNPs and CNMs may request, receive, and dispense pharmaceutical samples and may dispense drugs, including controlled substances. CNSs and CRNAs do not have Rx authority in California.

### Colorado

www.dora.colorado.gov/professions/nursing

www.campaign for action.org/state/colorado

#### Legal authority

The State BON grants advanced practice authority to RNs who meet the criteria set forth in the Colorado NPA and the BON R&Rs for inclusion on the Advanced Practice Registry (APR), regulates the practice of APRNs, and affords title protection. APRNs are defined as "APN" in the State of Colorado and include CNP (NP in statute), CNS, CNM, and CRNA roles. APNs are deemed to be independent practitioners. National certification in a role and population focus is required of all APR applicants.

APNs listed on the registry prior to July 1, 2010, may retain their listing on the APR without certification so long as the APN does not allow his or her advanced practice authority to lapse or expire. APNs engaged in an independent practice must be covered by professional liability insurance.

The scope of advanced practice nursing is based on the professional nurse's SOP within the APN role and population focus, which may include, but is not limited to, performing acts of advanced assessment, diagnosing, treating, prescribing, ordering, selecting, administering, and dispensing diagnostic and therapeutic measures.

The NPA and BON rules do not address, and therefore, do not prohibit APNs from being designated as PCPs or being granted hospital privileges; however, APNs are not currently recognized as PCPs in statutes and regulations under the jurisdiction of state agencies regulating healthcare. CNMs are now a recognized provider type for Colorado's Medicaid program known as Health First Colorado.

#### Reimbursement

Medicaid reimburses APN services; however, some managed-care Medicaid companies restrict independent APNs from joining networks. Third-party reimbursement is available to APNs, but third-party payers are not mandated to credential, empanel, or reimburse APNs.

#### Prescriptive authority

APNs have full Rx authority authorized by the BON within their recognized role and population focus, including Schedule II-V controlled substances. APNs must complete a 1,000-hour documented prescribing mentorship period (provisional Rx authority) with a physician or an APRN and registration with the DEA.

A one-time attestation signature is required following completion of the mentorship for verification and the existence of an articulated plan for safe prescribing. The attestation form is kept on a file at the BON. The APN is responsible for reviewing his or her articulated plan on an annual basis, and articulated plans may be audited by the BON. BON rules authorize APNs with Rx authority to receive and distribute a therapeutic regimen of prepackaged and labeled drugs, including free samples.

### Connecticut

www.ct.gov/dph/cwp/view.asp?a=3143&q=388910 www.ctaprns.org

www. campaign for action. or g/state/Connecticut

#### Legal authority

APRNs are defined in the NPA, regulated by the Connecticut State Board of Examiners for Nursing, and include CNP (NP in statute), CNS, and CRNA roles. APRNs are granted FPA following no less than 3 years and not less than 2,000 hours of APRN practice in collaboration with a physician. APRN SOP, independent practice, and collaborative practice are defined in statute by the BON. Additionally, the NPA specifically authorizes RNs to operate under an order issued by an APRN. Passage of Public Act No. 16-39 in 2016 authorizes global signature authority for APRNs in several situations, including certification for medical marijuana use (except for glaucoma), among other provisions.

APRNs are statutorily recognized as PCPs and are authorized to admit patients and hold hospital privileges. A graduate degree in nursing or other related field and national board certification are required to enter into practice. CNM authority is regulated by the Department of Public Health, and SOP is recognized under a separate statute (Chapter 377, Midwifery).

#### Reimbursement

Medicaid regulations govern reimbursement to APRNs under the remaining Medicaid fee-for-service programs. NPs, PCNSs, and CNMs are reimbursed for services under state insurance statutes, which affect only private insurers. Reimbursable services must be within the individual's SOP and must be services that are reimbursed if provided by any other healthcare provider. The law further states that insurers cannot require supervision or signature by any other healthcare provider as a condition of reimbursement.

#### Prescriptive authority

Following the passage of Public Act No. 14-12 in 2014, APRNs may independently prescribe, dispense, and administer medications autonomously, including Schedules II-V controlled substances following no less than 3 years and not less than a 2,000-hour transition to practice period. APRNs and CNMs are legally authorized to request, receive, and dispense pharmaceutical samples.

### Delaware

https://dpr.delaware.gov/boards/nursing www.denurses.org

www. campaign for action. or g/state/delaware

#### Legal authority

APRNs are licensed and regulated by the Delaware BON and include CNP, CNS, CNM, and CRNA roles. APRNs enjoy FPA as defined in section 1935 of the Delaware NPA; however, the statute is clear that FPA does not equate to the granting of independent practice. The BON may grant APRNs "independent practice" following review and recommendation of the APRN Committee.

Independent practice is defined as practice and prescribing by an APRN who is not subject to a collaborative agreement and works outside the employment of an established healthcare organization, healthcare delivery system, physician, podiatrist, or practice group owned by a physician or podiatrist.

Independent practice may be granted when an APRN has submitted written evidence of practice under a collaborative agreement with a hospital or integrated clinical setting for at least 2 years and a minimum of 4,000 full-time hours when the practice is substantially related to the population and focus area of the APRN.

APRNs have authority to serve as primary care providers by an insurer or healthcare services corporation. APRNs must graduate from or complete a graduate-level APRN program accredited by a national accrediting body and current certification by a national certifying body in the appropriate role and population focus area to be licensed in Delaware.

#### Reimbursement

Delaware has statutory provisions requiring health insurers, health service corporations, and HMOs to provide benefits for eligible services when rendered by an APRN acting within his or her SOP. APRNs may be listed on provider panels, and some providers are recognizing APNs on managed-care provider panels. CNMs have legislative authority under the Board of Health for third-party reimbursement. FNPs and PNPs also receive Medicaid reimbursement at 100% of the physician payment.

#### Prescriptive authority

APRNs licensed by the BON may prescribe, order, procure, administer, store, dispense, and furnish OTC, legend, and controlled substances pursuant to applicable state and federal laws and within the APRN's role and population focus. APRNs may receive, sign for, record, and distribute sample medications to patients in accordance with state law and DEA laws, regulations, and guidelines.

# District of Columbia

http://doh.dc.gov/service/board-nursing www.npadc.org

www.campaignforaction.org/state/district-of-columbia

#### Legal authority

The Washington D.C. Department of Health BON approves and regulates APRNs. APRNs include CNP (NP title in D.C.), CNS, CNM, and

CRNA roles. Current law authorizes APRNs to practice independently without a physician collaborative agreement or protocols. APRN SOP is defined in statute, is regulated by the BON, and is without limitations. APRNs may apply for hospital admitting privileges. National certification in a specialty area is required to enter into practice.

#### Reimbursement

APRNs receive direct reimbursement for providing drug abuse, alcohol abuse, and mental illness care; healthcare plans or institutions are prohibited from discriminating against APRNs with clinical privileges. Legislative authority mandating APRN reimbursement does not exist; however, private third-party payers reimburse for NP services. APRNs are statutorily recognized as PCPs. NPs and CNMs receive Medicaid payment as PCPs.

#### Prescriptive authority

The D.C. regulations provide for full Rx authority, including Schedules II-V controlled substances. The law and R&R authorize prescribing Schedules II-V controlled substances and allow dispensing of all medications, including sample medication. APRNs are authorized to request and receive pharmaceutical samples. The D.C. Pharmacy Board issues a Controlled Substance Registration to providers with controlled substance authority; however, APRNs must also hold DEA registration. Prescriptions are labeled with the APRN's name.

### Florida

www.floridasnursing.gov www.floridanurse.org

www.campaignforaction.org/state/florida

#### Legal authority

APRNs are defined as ARNPs and include CNP (NP in statute), CNM, and CRNA roles. The CNS role is defined in statute; however, CNSs do not have advanced practice authority. The BON certifies and regulates ARNPs and CNSs. ARNP SOP is defined in statute and includes the performance of medical acts of diagnosis, treatment, and operation pursuant to protocols established between the ARNP and an MD, DO, or dentist.

Within the framework of established protocols, ARNPs may order diagnostic tests, physical therapy, and occupational therapy. The degree and method of supervision (determined by the ARNP and MD, DO, or dentist) are specifically identified in written protocols and shall be appropriate for prudent healthcare providers under similar circumstances.

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ARNPs must file protocols with the BON when renewing their licenses; when there are changes to the protocol, the physicians working with the ARNP must send the statement required in the medical practice act to the BOM. BOM and BON rules define general supervision as the ability to communicate/contact by telephone; the supervising practitioner's on-site presence is not required.

ARNPs are authorized to admit patients to a hospital and hold hospital privileges; however, this authority is dependent upon privileges granted by the institution and the supervising physician. ARNP applicants must have a master's degree to qualify for initial certification and are required to hold national board certification to enter practice. CNSs must hold a master's degree in a clinical nursing specialty and either national certification in a CNS specialty or proof of completed clinical experience in a CNS specialty for which there is no national certification.

#### Reimbursement

ARNPs receive Medicaid, Medicare, CHAMPUS, and third-party reimbursement; however, Medicaid reimburses ARNPs at 100% of the physician rate only if the on-site physician countersigns the chart within 24 hours. Medicaid reimburses ARNPs at 85% of the physician rate if the physician is not on-site and does not countersign.

In 2008, Florida initiated a pilot program for Medicaid-managed care in which providers must be on approved panels. Managed-care companies are prohibited from discriminating against the reimbursement of ARNPs based on licensure. Private insurers must reimburse CNM services if the policy includes pregnancy care.

#### Prescriptive authority

Master's- or doctoral degree-prepared ARNPs are authorized by supervisory protocol to prescribe, dispense, administer, or order any drug, including Schedules II-V controlled substances as authorized in a BON-adopted controlled substances formulary with certain exceptions. Additionally, psychiatric mental health board-certified ARNPs may prescribe psychotropic controlled substances.

ARNPs prescribe under a protocol, which broadly lists the medical SOP and generic categories from which the ARNP can prescribe, and the controlled substances formulary describes limitations and restrictions based on specialty certification, approved uses of controlled substances, and other restrictions the committee finds necessary to protect the health, safety, and welfare of the public. ARNPs use their own

prescription pad (containing name and license number); the pharmacist is required to include the prescriber's name on the drug label. ARNPs are authorized to request, receive, or dispense pharmaceutical samples. CNSs do not have Rx authority in Florida.

# Georgia

http://sos.ga.gov/index.php/licensing/plb/45 https://uaprn.enpnetwork.com www.georgianurses.org

https://campaignforaction.org/state/georgia

#### Legal authority

APRNs are defined in statute and include CNP (NP in statute), CNM, CRNA, and CNS roles. A master's degree or higher in nursing (or other related field) and national board certification are required for all APRNs at entry into practice (with the exception of CRNAs educated prior to 1999). APRN practice authority is granted through 1 of 2 statutes: OCGA 43-34-25 and OCGA 43-34-23. APRNs authorized to practice under 43-34-23 are regulated by the BON. An APRN is authorized to perform advanced nursing functions and certain medical acts that include, but are not limited to, ordering drugs, treatments, and diagnostic studies through a "nurse protocol."

A nurse protocol is defined as a written document signed by the NP and physician in which the physician delegates authority to the nurse to perform certain medical acts and provides for immediate consultation with the delegating physician. The issuance of a written prescription is prohibited. APRNs practicing under OCGA 43-34-25 have Rx authority. There is joint regulation by the BON and BOM in that APRNs requesting Rx authority are required to submit, under BOM rules, a Nurse Protocol Agreement that must be approved by the BOM.

Practice under 43-34-25 prohibits APRNs from ordering certain radiographic imaging tests, such as magnetic resonance imaging and computed tomography scans, unless there are "life-threatening situations." There is a universal requirement for periodic review of a sampling of patient records as well as a requirement for patient evaluation and exam by the delegating physician in certain circumstances. Practice is delegated supervisory in nature. APRNs may hold hospital privileges in certain situations.

#### Reimbursement

There are no statutes mandating the third-party reimbursement for APRNs. FNPs, PNPs, WHNPs, CNMs, and CRNAs are eligible for Medicaid reimbursement from the Department of Community Health. Reimbursement rates vary: NPs and CRNAs are reimbursed at 90% of the physician payment, and CNMs are reimbursed at 100% of the physician payment. Some private insurers reimburse APRNs but are not required by law to do so.

#### Prescriptive authority

APRNs practicing under a nurse protocol as defined by OCGA 43-34-23, which describes a process that permits RNs (including APRNs) to administer, order, or dispense drugs under delegated medical authority as either prescribed by a physician or authorized by protocol. APRNs practicing under a Nurse Protocol Agreement defined and approved by the BOM as authorized by OCGA 43-34-25 may issue a written drug order, including Schedules III-V controlled substances, and request, receive, sign for, and distribute pharmaceutical samples. BON regulations governing protocols used by RNs require the RN to document preparation and performance specific to each medical act. "Medication orders" may be called into a pharmacy.

### Hawaii

www.hawaii.gov/dcca/pvl/boards/nursing www.campaignforaction.org/state/hawaii

#### Legal authority

The BON licenses and regulates APRNs in Hawaii consistent with the NCSBN APRN Consensus Model. APRNs include CNP (NP in regulation), CNS, CNM, and CRNA roles and have independent SOP and Rx authority. APRN SOP is defined in statute and regulation and conforms to the NCSBN Model Act. Legislation passed in 2016 authorizes APRNs to certify patients for medical marijuana use.

Hospitals licensed in Hawaii recognize APRNs, allow them to function with full SOP, and authorize APRNs to act as a PCP in their institutions. The minimum requirements to enter practice in Hawaii include completion of an accredited, graduate-level education program preparing the nurse for one of the four recognized APRN roles and national certification in the APRN's clinical specialty.

#### Reimbursement

Current law provides direct reimbursement to all APRNs and authorizes all insurers to legally recognize APRNs as PCPs. The reimbursement rate ranges from 85% to 100%. NPs and CNSs are also reimbursed through CHAMPUS. Medicaid expanded the types of APRNs they reimburse to include PCNSs and additional NP specialties. Medicaid reimburses at 75% of the physician payment. Hawaii Health QUEST, a Medicaid waiver program, defines PNPs, FNPs, and CNMs as PCPs.

#### Prescriptive authority

The BON regulates APRN Rx authority, and APRNs have legal authority to prescribe medications, including Schedules II-V controlled substances independently pursuant to an exclusionary formulary established by the BON. APRNs with Rx authority are legally authorized to request, receive, and dispense manufacturers' prepackaged pharmaceutical samples. APRNs may not request, receive, or sign for controlled substance samples; however, they may prescribe, order, and dispense medical devices and equipment.

APRN prescribers' prescriptions are labeled with the APRN's name.

### Idaho

https://ibn.idaho.gov/IBNPortal www.npidaho.org

www.campaignforaction.org/state/idaho

#### Legal authority

The BON regulates and grants FPA to APRNs. APRNs include CNP, CNS, CNM, and CRNA roles. APRN licensure requires RN licensure, completion of an approved APRN program, and national certification. NPA rules rely on the decision-making model to determine an APRN's SOP. The APRN can determine if a specific function can be legally performed by determining the following: if the act is expressly forbidden in the NPA Rules and Regulations, was taught in the APRN curriculum, acquired through additional education, whether the APRN is clinically competent to perform it, does not exceed employment policies, is consistent with national specialty organization standards, and is within the accepted standard of care for the APRN's geographic region and practice setting.

APRNs are not statutorily recognized as PCPs; however, Idaho has an "any willing provider" language in statute. APRNs are legally authorized to admit patients to hospitals and hold hospital privileges in Idaho. Some facilities have granted APRNs privileges. State law requires a minimum of a graduate/postgraduate degree as entry into practice; however, APRNs educated prior to January 1, 2016, are exempt from the requirement for a graduate/postgraduate degree. The NPA has previously required national board certification to enter practice, which requires a master's degree in nursing to enter into most specialties.

#### ■ Reimbursement

Listing APRNs on managed-care provider panels is neither permitted nor prohibited and is considered by third-party payers on an individual basis. BC/BS credentials CNPs as "preferred providers" within their program. CNPs receive their own Medicaid provider

number and may choose to file independently or with a group. Reimbursement rates are 85% of the physician payment.

#### Prescriptive authority

Rx and dispensing authority is granted to APRNs who have completed 30 contact hours of pharmacology-specific formal instruction beyond basic RN education or who graduated from their APRN educational program after December 31, 2015. Authorized APRNs may prescribe and dispense legend and Schedules II-V controlled substances appropriate to their defined SOP. Authorized APRNs have their own DEA numbers and prescribe independently. APRNs are legally authorized to request, receive, and dispense pharmaceutical samples, and APRN prescriptions are labeled with the APRN's name only.

### Illinois

www.idfpr.com/profs/nursing.asp www.isapn.org

www.campaignforaction.org/state/illinois

#### Legal authority

APRNs are defined as APNs in the State of Illinois and include CNP, CNS, CRNA, and CNM roles. The Illinois Department of Financial and Professional Regulation (IDFPR) grants authority and regulates APN practice. APNs must have a written collaborative agreement with a physician, podiatrist, or dentist, except for APNs who provide services in a hospital, hospital affiliate, or ASTC and have been granted clinical privileges by that facility. The requirement to consult with a physician every month was eliminated when HB 421 was signed into law July 29, 2015 (except in the situation of the APN's prescribing Schedule II medications).

Communication methods (in person or electronic) with the collaborating physician or podiatric physician must be stipulated in the written agreement. New APN applicants must have a graduate degree or a postmaster's certificate from a graduate-level program appropriate for national certification in a clinical advanced practice nursing specialty. Additionally, the APN must hold current RN licensure and national certification as a CNP, CNS, CNM, or CRNA from the appropriate national certifying body as determined by rule of IDFPR. All APNs may practice only in accordance with their national certification.

There is an exception to the graduate degree requirement for CRNAs who completed their CRNA program prior to January 1, 1999, and have kept their certification current. This exception will expire on June 30, 2018. If a collaborative agreement with a physician or podiatrist is

terminated, the APN is authorized to continue to practice up to 90 days after the termination of the agreement, provided the APN seeks any needed collaboration at a local hospital and refers patients who require services beyond the training and experience of the APN to a physician or other healthcare provider.

#### Reimbursement

The Illinois Department of Healthcare and Family Services (HFS) administers the Illinois Medicaid program. APNs who enroll as providers in the department's medical programs are reimbursed at 100% of the physician rate. Medicaid recipients are being transitioned to Medicaid MCOs; therefore, in addition to enrolling as HFS providers, APNs must also enroll as providers for each Medicaid MCO for which any of their patients are members. Statutory prohibition for third-party reimbursement to APNs does not exist. APNs receive direct or indirect reimbursement from some third-party payers.

#### Prescriptive authority

Rx authority, including prescribing Schedules II-V controlled substances, may be delegated to an APN by a physician or podiatrist as a part of the written collaborative agreement or may be authorized by clinical privileges in a hospital, hospital affiliate, or ASTC. Delegation to prescribe controlled substances must be noted in the written collaborative agreement or otherwise authorized by the hospital, hospital affiliate, or ASTC.

If delegated to prescribe controlled substances, an APN shall apply for a Mid-Level Practitioner Illinois Controlled Substances License and a federal DEA number. In the case of Schedule II substances, APNs can prescribe such medications in only oral, transdermal, or topical forms.

For APNs prescribing controlled substances under a written collaborative agreement, the collaborating physician or podiatric physician must have a valid, current Illinois controlled substance license and federal registration. In the case of prescribing Schedule II controlled substances, such delegation, whether by written collaborative agreement or by privileging by a hospital, hospital affiliate, or ASTC, must identify the specific Schedule II controlled substances by either brand name or generic name.

Medication orders shall be reviewed periodically by the collaborating physician or podiatric physician or appropriate hospital affiliate physicians committee or its physician designee. Any prescription for a Schedule II controlled substance must be limited to no more than a 30-day supply.

Prior to renewal of a prescription of a Schedule II controlled substance, the APN must

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discuss the patient's condition monthly with the collaborating physician or appropriate physician committee of the hospital affiliate or its physician designee. As noted in the Illinois Controlled Substances Act, APNs who prescribe Schedule II controlled substances must have completed at least 45 graduate contact hours in pharmacology for any new controlled substance license issued with Schedule II authority and must annually complete 5 hours of CE in pharmacology for license renewal.

### Indiana

www.in.gov/pla/nursing.htm www.indiananurses.org www.campaignforaction.org/state/indiana

#### Legal authority

APRNs are defined as APNs in the State of Indiana and include CNP (NP in regulation), CNM, CNS, and CRNA roles. The Indiana State BON grants the authority to and regulates APNs. The BON does not issue additional, separate licenses or certification to NPs or CNSs; however, CNMs must apply for "limited licensure" to practice. APNs without Rx authority may function independently in their advanced practice; however, a written CPA is necessary if the APN seeks Rx authority.

APN SOP is defined in regulation. National certification is required to obtain Rx authority if the APN holds a baccalaureate degree. APNs with a graduate degree do not need to be nationally certified for Rx authority to be granted. CNSs are required to hold a minimum of a master's degree to practice.

In hospitals, APNs are authorized to practice in collaboration with a licensed practitioner as evidenced by a practice agreement; by privileges granted by the governing board of a hospital licensed under IC 16-21 (hospitals) with the advice of the medical staff that sets forth the manner in which the APN and licensed practitioner will cooperate, coordinate, and consult with each other; or by privileges granted by the governing body of a hospital operated under IC 12-24-1 (state hospitals) that set forth the manner in which the APN and licensed practitioner will cooperate, coordinate, and consult with each other.

#### Reimbursement

Indiana is considered an "any willing provider" state backed by current law. APNs may receive third-party reimbursement as determined by payers. NPs receive Medicaid reimbursement at 85% of the physician payment. Medicaid for children, however, does not allow for NP reimbursement under current managed-care arrangements. Recent legislation in 2016 directs Medicaid managed

care and fee-for-service plans to reimburse NPs and CNSs employed by community mental health centers for services as specified.

#### Prescriptive authority

The BON has legal authority to establish rules, and with the approval of the BOM, to permit Rx authority for APNs. The BON may issue authorization to prescribe legend drugs and controlled substances if the qualified APN submits proof of successful completion of a graduate-level pharmacology course consisting of at least 2 accredited semester hours. Additionally, the APN must submit proof of collaboration with a "licensed practitioner" (licensed physician, dentist, podiatrist, or osteopath) in the form of a written CPA.

Written CPAs must be approved by the BON and include the manner in which the APN and licensed physician will cooperate, coordinate, and consult with each other in the provision of healthcare, and the specifics of the licensed physician's reasonable and timely review of the APN's Rx practices, including the provision for a minimum weekly review of 5% random chart sampling. The BON issues a Rx authority ID number: the authority limits APN prescribing to within the APN's and collaborating physician's SOP.

APNs requesting authority to prescribe controlled substances must apply for and obtain Indiana State Controlled Substances Registration before obtaining a federal DEA number. Prescriptions are labeled with the APN's name only. Recent legislation authorizes NPs to prescribe legend drugs to patients receiving care via telemedicine if they have established a provider-patient relationship, satisfy the standard of care, and document the prescription in the medical record.

APNs with Rx authority are authorized to prescribe Schedules III and IV controlled substances for the purpose of weight reduction or to control obesity (Indiana Code 35-48-3-11) after certain conditions are met, which was prohibited under this code until 2015. Additionally, IC 25-1-9-6.8 requires practitioners to follow the most recent guidelines adopted by the American Academy of Pediatrics or American Academy of Child and Adolescent Psychiatry when prescribing stimulant medications for attention-deficit disorder or attention-deficit hyperactivity disorder. CRNAs are not required to obtain Rx authority to administer anesthesia.

### lowa

www.nursing.iowa.gov www.campaignforaction.org/state/iowa

#### Legal authority

APRNs are defined as ARNPs in the state of Iowa, which includes CNP, CNS, CNM, and

CRNA roles. The ARNP is certified by a national professional certification organization in at least one population focus, which includes family/individuals across the lifespan, adult/gerontology, neonatal, pediatrics, women's health/gender, and psychiatric mental health.

ARNPs are authorized to practice independently within their specific role and population focus, and collaborative practice agreements are not required by the BON. SOP is broadly defined. ARNPs are statutorily recognized as primary care providers; however, state law does not contain "any willing provider" language. ARNPs may hold hospital clinical privileges. Licensure as an ARNP requires current licensure as an RN and certification by a national professional certification organization. The majority of ARNPs are educated at the master's or doctoral level.

#### Reimbursement

Iowa's Medicaid managed-care and prepaid-service programs reimburse ARNPs. Payment of necessary medical or surgical care and treatment is provided to an ARNP in third-party reimbursement if the policy or contract would pay for the care and treatment when provided by a physician or DO. MCOs are not mandated to offer ARNP coverage unless there is a contract or other agreement to provide the service. All ARNPs are approved as providers of healthcare services pursuant to managed-care or prepaid-service contracts under the medical assistance program.

#### Prescriptive authority

Authorized ARNPs are granted full, independent Rx authority within their specific role and population focus, including Schedules II-V controlled substances, ARNPs may prescribe, deliver, distribute, or dispense noncontrolled and controlled drugs, devices, and medical gases, including pharmaceutical samples. ARNPs must register with the DEA, and prescriptions written by ARNPs must be labeled with their name.

### Kansas

www.ksbn.org www.kansasnps.com www.campaignforaction.org/state/kansas

#### Legal authority

The Kansas BON grants authority to APRNs and regulates the practice, issuing a separate license. Recognized APRN roles include CNP (NP in regulation), CNS, CNM (NM in regulation), and CRNA (RNA in statute). CNPs, CNSs, and CRNAs function in collaborative relationships with physicians

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and other healthcare professionals in the delivery of primary healthcare services. The Independent Practice of Midwifery Act in 2016 authorizes CNMs to practice without a collaborative agreement when such services are limited to those associated with a normal, uncomplicated pregnancy and delivery. APRNs make independent decisions about the nursing needs of patients and interdependent decisions with physicians in carrying out health regimens for patients; however, the physical presence of a physician is not required when care is given by the APRN.

Any CNP, CNS, or CRNA who interdependently develops and manages the medical plan of care for patients or clients is required to have a signed authorization for collaborative practice with a physician who is licensed in Kansas (60-11-010 [b]). Each authorization for collaborative practice shall be maintained in either hard copy or electronic format at the APRN's principal place of practice.

SOP is defined in statute and regulation; however, APRNs are not recognized as PCPs. No specific language in statute authorizes or prohibits hospital privileges; admitting and hospital privileges are determined by individual institution policy and procedure. APRN applicants in all categories require a master's degree or higher in nursing, and national board certification is not required to enter practice in Kansas (except for RNAs).

#### Reimbursement

Insurance companies are legally required to reimburse all APRNs for covered services in health plans. Medicaid has expanded payment to include all covered services at 80% of the physician payments (except for practitioners performing early periodic screening diagnosis and treatment who receive 100%). NAs receive 85% of physician payments. Some insurance companies are paying 85% of physician payments to APRNs.

#### Prescriptive authority

APRNs, with the exception of CRNAs, are legally authorized to prescribe medications, including Schedules II-V controlled substances pursuant to a collaborative practice agreement and written protocol. The protocol must contain a precise and detailed medical plan of care for each classification of disease or injury for which the APRN is authorized to prescribe and shall specify all drugs, which may be prescribed by the APRN. These can be published protocols or practice guidelines that have been agreed upon by both the APRN and physician.

CNMs may prescribe drugs and devices without a collaborative practice agreement when the service is associated with family planning services, including treatment or referral of a male partner for STIs, initial care

of the newborn, and a normal, uncomplicated pregnancy and delivery. The prescription order must be signed by the APRN and include the name of the physician and APRN.

APRNs must register with the DEA and the BON if they prescribe controlled substances. Prescription labels include both the APRN's and physician's name. APRNs are authorized to request, receive, and distribute pharmaceutical samples—and with the exception of controlled substances—if the drug is within their protocol.

# Kentucky

www.kbn.ky.gov www.kcnpnm.org

www.campaignforaction.org/state/kentucky

#### Legal authority

The Kentucky BON grants APRNs authority to practice and regulates their practice. APRNs are statutorily defined as CNPs, CNSs, CNMs, and CRNAs. APRNs practice autonomously within their relative SOPs; however, they must practice in accordance with the SOP of the national certifying organization as adopted by the BON in regulation (collaborative agreement is required for certain Rx authority; see detail below).

CNP SOP is defined in Kentucky statute KRS 314.011. "APRNs shall seek consultation or referral in situations outside their SOP (201 KAR 20:057, Section 3)." APRNs are recognized as practitioners in statute (KRS 314.195), included in the definition of "practitioner" for prescribing (KRS 217.015 [35], KRS 218A.010 [33]), and are legally authorized to admit patients to a hospital and hold hospital privileges; however, hospital regulations permit medical staff to set conditions (902 KAR 20:016 Section3 [8][b][2] [b]). A master's degree, doctorate, or postmaster's certificate as an APRN and national board certification are required to enter practice in Kentucky.

#### Reimbursement

The state medical assistance program reimburses APRNs for services at 75% of the physician rate in all state regions. Kentucky is an "any willing provider" state. In April 2003, the U.S. Supreme Court upheld the Kentucky law providing that a health insurer may not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer.

#### Prescriptive authority

APRNs have autonomous Rx authority for nonscheduled legend drugs following 4 years

of prescribing experience under a Collaborative Agreement for Prescriptive Authority for Nonscheduled Drugs (CAPA-NS) with a physician licensed in Kentucky. Prescribing of Schedules II-V controlled substances is authorized pursuant to a permanent Collaborative Agreement for Prescriptive Authority for Controlled Substances (CAPA-CS). The CAPA-CS and -NS define an APRN's scope of prescribing authority and are signed by the APRN and the physician. Legislation in 2015 removed the CAPA-NS requirement following 4 years of experience; however, the CAPA-CS is still required.

APRNs may prescribe scheduled medications with the following limitations: Schedule II controlled substances for a 72-hour supply with two exceptions: Certified Psychiatric/ Mental Health APRNs may prescribe a 30-day supply of psychostimulants, and all APRNs may prescribe a 30-day supply of Schedule II controlled hydrocodone-combination products without refill.

Legislation in 2017 (HB 333) limits all prescribers to a 72-hour supply of Schedule II controlled substances (including hydrocodone-combination products) when prescribing the Schedule II controlled substance for acute pain, with exceptions including documentation for more than a 72-hour supply for acute pain justifying deviation from the 3-day supply; chronic pain; pain associated with a valid cancer diagnosis; pain associated with end-of-life treatment; part of a narcotic treatment program; pain following a major surgery or treatment of significant trauma; or dispensed or administered directed to an ultimate user in an inpatient setting.

State licensing boards are not authorized to promulgate regulations that expand any practitioner's Rx authority beyond that which existed prior to the effective date of this Act. Schedule III controlled substances may be prescribed for a 30-day supply without refills; Schedules IV and V controlled substances may be prescribed with refills not to exceed a 6-month supply with the following limitations: diazepam, clonazepam, lorazepam, alprazolam, and carisoprodol may be prescribed for 30 days without refills. Gabapentin was rescheduled as a Schedule V in Kentucky in 2017 and will be recorded and monitored in the Kentucky prescription drug monitoring program. CRNAs do not need CAPAs to deliver anesthesia care.

The APRN alone signs his or her name to the prescription pad when prescribing, using his or her DEA number for controlled substances. APRNs must complete 5 pharmacology contact hours annually as part of their CE requirement (all APRNs with a CAPA-CS must include 1.5 of the 5 contact

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hours related to the use of the prescription monitoring system, pain management, or addiction disorders).

APRNs are legally authorized to request and receive, as well as dispense, nonscheduled legend pharmaceutical samples. APRNs may also dispense nonscheduled legend drugs from local, district, and independent health department settings subject to the direction of the appropriate governing board of the individual health department.

### Louisiana

www.lsbn.state.la.us www.lanp.org

www.campaignforaction.org/state/louisiana

#### Legal authority

APRNs are licensed by the BON and include CNP (NP in statute), CNM, CRNA, and CNS roles. APRNs perform certain acts of medical diagnosis in accordance with a CPA, a formal written statement addressing the parameters of the collaborative practice that are mutually agreed upon by the APRN, physician(s), or dentist(s), including consultation or referral availability, clinical practice guidelines, and patient coverage.

APRNs' SOP is addressed in regulation in that "patient services provided by an APRN must be in accord with the educational preparation of that APRN." The APRN SOP includes the following: certain acts of medical diagnosis or medical prescriptions of a therapeutic or corrective nature; prescribing assessment studies; legend and certain controlled drugs; therapeutic regimens; medical devices and appliances; receiving and distributing a therapeutic regimen of prepackaged drugs prepared and labeled by a pharmacist; and free samples supplied by a drug manufacturer (excluding receipt of samples of controlled substances).

Louisiana State law includes "any willing provider" language, and APRNs are legally authorized to hold hospital privileges. APRNs must be licensed as an RN, possess a master's degree or higher, and be certified by a national certifying body recognized by the BON, or meet "commensurate requirements" if certification is not available.

#### Reimbursement

Prior legislation prohibits qualified plans from excluding direct reimbursement of healthcare services provided by an APRN. Medicaid recognizes NPs, CNSs, and CNMs as PCPs and will recognize those APRNs as the PCP or "medical home" under certain circumstances. APRNs are reimbursed at 80% of the physician fees per Medicaid; some immunizations and certain screening services for children are reimbursed at 100%. All billing

must be under the APRN's provider number, essentially eliminating "incident to" billing, though that option is available under certain conditions.

#### Prescriptive authority

APRNs have Rx authority in Louisiana, including Schedules II-V controlled substances. The BON has sole authority to develop, adapt, and revise R&R governing SOP, including Rx authority, the receipt and distribution of sample and prepackaged drugs, and prescribing legend and controlled drugs. An APRN who is granted limited Rx authority may request approval to prescribe and distribute controlled substances as authorized by the APRN's collaborating physician if the patient population is served by the collaborative practice. Legislation enacted in 2017 limits all medical practitioners to a 7-day supply of opioid medication when issuing a first-time prescription for outpatient use to an adult with an acute condition. Exceptions to the limitation are provided for in the new law.

Recent amendment of regulations (Title 46, Part XL VII, §4513) provides for CRNA Rx authority without a collaborative practice agreement when prescribing or writing orders in a hospital or other licensed surgical facility for services related to anesthesia care.

### Maine

www.state.me.us/boardofnursing www.mnpa.us

www.campaignforaction.org/state/maine

#### Legal authority

The Maine BON authorizes and regulates APRN practice. APRNs licensed by the BON are defined as CNPs, CNMs, CNSs, and CRNAs. CNSs practice in an independent role; however, a CNP who qualifies as an APRN must practice for at least 24 months under the supervision of a licensed physician, NP, or must be employed by a clinic or hospital that has a medical director who is a licensed physician. The CNP must submit written evidence to the BON upon completion of the required clinical experience. Following this period, the CNP practices independently.

CRNAs are responsible and accountable to a physician or dentist except for services provided in critical access or rural hospitals following enactment of legislation in 2017; CRNAs are authorized to order appropriate lab tests and diagnostic imaging tests in the peri- and immediate postoperative periods. The APRN SOP, as defined in regulation, includes standards of the national certifying body and "consultation with or referral to medical and other healthcare providers when required by client healthcare needs." Psychiatric and mental health CNPs and certified PCNSs may sign documents for emergency, involuntary commitment through EDs. CNPs are authorized to certify patients to receive therapeutic or palliative benefit from medical use of marijuana.

APRNs are statutorily defined as "PCPs" and may be credentialed as allied staff for hospital privileges. Admitting privileges are not granted in this authority. Workers' compensation forms recognize CNPs and allow issuance of license plates and cards for the physically disabled. Current law requires a master's degree in nursing and national certification to enter into practice.

#### Reimbursement

The 1999 Act to Increase Access to Primary Health Care Services requires reimbursement under an indemnity or managed-care plan for patient visits to an NP or CNM when referred from a PCP; requires insurers to assign separate provider ID numbers to CNPs and CNMs; and allows managed-care enrollees to designate CNPs as their PCP. However, MCOs are not required to credential any physician or CNP if their "access standards" have been met.

Reimbursement under indemnity plans is mandated for master's-prepared, certified psychiatric/mental health CNSs; no other third-party reimbursement for APRNs is required by law. Some insurance carriers, however, reimburse independent CNPs. Medicaid reimburses in full, on a fee-forservice basis, for services provided by certified family NPs, CPNPs, and CNMs.

#### Prescriptive authority

CNPs and CNMs may prescribe and dispense drugs or devices, including Schedule II-V controlled substances, in accordance with rules adopted by the BON; approved CNPs and CNMs receive their own DEA numbers. BON rules require CNPs and CNMs to have a pharmacology course and prescribe from FDA-approved drugs related to the nurse's specialty.

CNPs and CNMs may prescribe Schedule II-V controlled substances and drugs off-label, according to common and established standards of practice. CNPs and CNMs may receive and distribute drug samples included in the formulary for prescription writing.

New statutes passed in 2017 authorize a CRNA to order and prescribe medication in the peri- and postoperative period. CRNAs may prescribe Schedules III, IIIN, IV, and V controlled substances only (1) for a supply of not more than 4 days with no refills; and (2) for an individual for whom the CRNA has at the time of the prescription, established a client or patient record.

# Maryland

www.mbon.org www.npamonline.org www.maapconline.org www.campaignforaction.org/state/maryland

#### Legal authority

The Maryland BON regulates APRN practice. APRNs include CNP (NP or CRNP in statute), CRNA, CNM, and CNS roles. Maryland also recognizes nurse psychotherapists as APRNs (APRN/PMH). NP SOP is independent, defined in statute and regulations, and is in accordance with the Standards of Practice of the American Association of Nurse Practitioners or any other national certifying body recognized by the BON.

Scope and standards of independent practice for NPs are defined in statute and regulations. CRNAs maintain an affirmation of collaboration with the BON containing the name and license number of an anesthesiologist, physician, or dentist; CNPs, CNMs, and CNSs practice independently without a collaborative practice agreement. A master's degree is the minimum required degree to enter practice in Maryland in addition to national board certification.

NPs and CNMs holding a State controlled dangerous substances registration, registration with the Maryland Medical Cannabis Commission, and are in good standing with the State BON may issue written certification for medical marijuana use to qualifying patients.

#### Reimbursement

All nurses are entitled to private third-party and Medicaid reimbursement for services if they are practicing within their legal SOP. All Medicaid recipients have been assigned to an MCO; CNPs (with the exception of neonatal and acute care) and CNMs have been designated as PCPs and may apply to be placed on a provider panel. Medicaid reimburses at 100% of physician payment.

Recent legislation requires Medicaid to reimburse PCPs for telemedicine services. The law allows due process for APNs listed on managed-care panels; APRNs are not to be arbitrarily denied. The law does not require, however, that an HMO include CNPs on the HMO panel as PCPs. Several commercial insurers reimburse NPs directly, however, at a rate of 75% to 85% of a physician's fee schedule.

#### Prescriptive authority

CNPs and CNMs have full Rx authority, including Schedule II-V controlled substances. The scope of Rx authority is defined in statute. CNPs and CNMs are authorized to obtain both federal and state DEA numbers. CNPs are legally authorized to dispense

medications in public health settings and student health clinics. Prescription containers are labeled with the CNP or CNM name.

### Massachusetts

www.mass.gov/dph/boards/rn www.mcnpweb.org www.campaignforaction.org/state/ massachusetts

#### Legal authority

The Massachusetts BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP, CRNA, PCNS, CNS, and CNM roles. Advanced practice R&Rs governing the ordering of tests, therapeutics, and prescribing are promulgated by the BON with concurrence from the BOM; all other areas of SOP are exclusively under the BON. SOP is defined both in statute and regulation.

Massachusetts recognizes APRNs as PCPs; however, state law does not contain "any willing provider" language. Credentialing for hospital privileges varies according to hospital policies. Massachusetts mandates a minimum of a graduate degree for initial (not reciprocal) APRN authorization. National certification is required to enter into and remain in practice.

#### Reimbursement

FNPs, PNPs, and adult NPs are reimbursed at 100% of the physician rate for Medicaid unless the NP is employed by the hospital in a hospital-based practice. Massachusetts state law mandates reimbursement to NPs, PCNSs, NMs, and NAs in accordance with Chapter 302 of the Acts and Resolves of 1994. These include indemnity plans, nonprofit hospital corporations, medical service corporations, and HMOs.

BC/BS, Fallon, and Neighborhood Health Plan credential NPs in private practice settings to receive individual provider numbers. Effective January 2009, all health insurers are required to recognize NPs as PCPs and include them in provider directories for consumer choice.

#### Prescriptive authority

Massachusetts state law provides for Rx authority for CNPs, CNMs, CRNAs, and PCNSs, including Schedule II-V controlled substances. Authorized APRNs must apply to the Massachusetts Department of Public Health for state registration and then apply for a federal DEA number. CNPs, CRNAs, and PCNSs must establish written guidelines developed in collaboration with the nurse and supervising physician, which include a defined mechanism to monitor prescribing

practices and must designate a physician who will provide medical direction for Rx practice as is customarily accepted in the specialty area.

Initial prescription of Schedule II controlled substances requires review within 96 hours. Authorized APRNs are allowed to request, receive, and dispense pharmaceutical samples. The prescription pad of the CNP, CRNA, and PCNS includes the name of the supervising physician and the APRN; however, the authorized APRN signs the prescription.

# Michigan

www.minurses.org
www.micnp.org

www.campaignforaction.org/state/michigan

#### Legal authority

The Michigan BON grants legal authority to practice and regulates the practice of APRNs through certification issued to them as an RN. Newly defined in statute, APRNs include RNs who have been granted a specialty certification by the BON in the following roles: CNP, CNS, and CNM. CRNAs (NA in statute) are recognized by the BON and granted specialty certification but are not categorized as APRNs in statute. According to the Michigan Council of Nurse Practitioners (although no statute exists requiring supervision or collaboration to practice with the exception of Rx authority), the state has interpreted NP practice as "supervised" due to their ability to "diagnose," which is defined as the practice of medicine.

The certification recognizes the additional training and completion of a certification program that enables the RN to handle tasks of a more specialized nature that are delegated to him or her. APRN SOP is not defined within statute, and thus, is considered the RN SOP and what tasks can be delegated by another licensee, which is typically a physician.

Under some HMOs and systems, CNPs are recognized as PCPs. Michigan does not have "any willing provider" language in statute. Michigan statute does not specifically authorize APRNs to admit patients or hold hospital privileges; however, this is dependent on the institution, and hospitals generally grant these privileges. APRNs are required to have a graduate degree in nursing and national board certification to enter into practice.

#### Reimbursement

Medicaid directly reimburses all certified CNPs at 100% of the reimbursement rate. CRNAs and CNMs are also recognized by

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Medicaid and directly reimbursed. BC/BS directly reimburses all CNPs, CNMs, and CRNAs; however, the statute does not legally require insurance companies to credential, empanel, or recognize nurse specialists.

#### Prescriptive authority

APRNs are authorized to prescribe nonscheduled prescription drugs; prescribing of Schedules II-V controlled substances is authorized as a delegated act of a physician and must include the APRN and physician names and DEA numbers.

APRNs may order, receive, and dispense nonscheduled complementary starter dose drugs independently; however, delegation by a physician is required to order, receive, and dispense complementary starter doses of Schedules II-V controlled substances. Prescription labels include both the APRN and physician name.

### Minnesota

www.nursingboard.state.mn.us www.mnnp.org https://mnaprnc.enpnetwork.com/ www.campaignforaction.org/state/minnesota

#### Legal authority

The Minnesota BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP, CNS, CNM, and CRNA roles. APRNs have independent practice in Minnesota. CNPs and CNSs are required to complete a "postgraduate practice" period of at least 2,080 hours within the context of a collaborative agreement with a physician or APRN within a hospital or integrated clinical setting where APRNs and physicians work together to provide patient care.

CRNAs and CNMs do not have a postgraduate practice requirement. APRN SOP is defined in statute and must be consistent with their education and certification. APRNs are not statutorily prohibited from admitting patients and holding hospital privileges. Minnesota APRNs are licensed by the BON following completion of an accredited graduate-level APRN program and national certification by a recognized APRN certifying organization.

#### Reimbursement

APRNs may enroll with Medicaid as a provider and bill for services. FNPs, PNPs, GNPs, WHNPs, and ANPs are reimbursed by Medicaid at 90% of the physician rate. CNPs, CNMs, CRNAs, and CNSs have legal authority for private insurance reimbursement. Minnesota law prohibits HMOs and private insurers from requiring a physician's cosignature when an APRN orders a lab test, X-ray, or diagnostic test.

#### Prescriptive authority

APRNs may prescribe, receive, dispense, and administer drugs, including Schedules II-V controlled substances independently. CRNAs must hold a written prescribing agreement with a physician when providing nonsurgical pain therapies for chronic pain symptoms. APRNs must register with the DEA, and they have statutory authority to request, receive, and dispense sample medications.

# Mississippi

www.msbn.ms.gov/Pages/Home.aspx www.msnurses.org www.campaignforaction.org/state/mississippi

#### Legal authority

The Mississippi BON grants APRNs the authority to practice and regulates their practice, APRNs include CNP, CNS, CNM, and CRNA roles. CNPs, CRNAs, and CNMs practice in a collaborative relationship with physicians in Mississippi. The collaborating physicians' practice must be compatible with the CNP's practice. APRNs must practice according to a BON-approved protocol agreed on by the APRN and physician. Practicing in a site not approved by the BON (with a physician not approved by the BON or according to a protocol not approved by the BON) is in violation of the NPA R&Rs.

SOP is defined and regulated by the BON. CNPs are statutorily recognized as PCPs; however, Mississippi law does not contain "any willing provider" language. APRNs are legally authorized to admit patients and hold hospital privileges. APRNs are required to have a master's degree or higher in nursing, nurse anesthesia, or midwifery, and must be nationally certified to enter into practice.

#### Reimbursement

Medicaid reimbursement is available to APRNs at 90% of the physician payment. Insurance law specifies that whenever an insurance policy, medical service plan, or hospital service contract provides for reimbursement for any service within the SOP of a CNP working under the supervision of a physician, the insured shall be entitled to reimbursement whether the services are performed by the physician or NP. Reimbursement is increased to 100% for CNPs who provide healthcare services after 5:00 p.m.

#### Prescriptive authority

CNPs and CNMs have full Rx authority, including Schedules II-V controlled substances, based on the standards and guidelines of the CNP or CNM's national certification organization and a BONapproved protocol that has been mutually agreed on by the CNP or CNM and qualified physician. The protocol must outline diagnostic/therapeutic procedures and categories of pharmaceutical agents that may be ordered, administered, dispensed, and/or prescribed for patients with diagnoses identified by the CNP.

CNPs may receive and distribute prepackaged medications or samples of noncontrolled substances for which the NP has Rx authority. Schedules II-V controlled substances may be prescribed pursuant to additional BON rules and regulations: the NP must have a DEA number, completed a BON-approved educational program, and submitted a "controlled substance Rx authority protocol" to the BON. CNMs and CRNAs may order controlled substances within a licensed healthcare facility using BON-approved protocol or practice quidelines.

### Missouri

www.pr.mo.gov/nursing.asp www.missourinurses.org www.campaignforaction.org/state/missouri

#### Legal authority

The Missouri BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP, CNS, CNM, and CRNA roles. APRNs practice in collaboration with physicians in Missouri. Collaborative practice includes written agreements, written protocols, or written standing orders. R&Rs define the Collaborative Practice (CP) rule.

Three focus areas in the CP rule include geographic areas to be covered, methods of treatment that may be covered by CP arrangements, and requirements for review of services provided pursuant to a CP arrangement. A written CP arrangement with a physician is not needed when the APRN is performing nursing acts consistent with the APRN's skill, training, education, and competence.

A CP arrangement may be indicated to perform physician-delegated medical acts within the mutual SOP of the physician and APRN and consistent with the APRN's skill, training, education, and competence. CRNAs practice under the direction of the surgeon, anesthesiologist, dentist, or podiatrist and are not required to have a collaborative practice arrangement. Individuals are recognized by their specific clinical nursing specialty area as a CNP, CNS, CNM, or CRNA, which delineates their title and SOP as APRNs in R&Rs.

When practicing outside their recognized clinical nursing specialty, individuals must practice and title as RNs only. Missouri law does not recognize APRNs as PCPs and does not contain "any willing provider" language. Additionally, APRNs are not legally authorized to admit patients or hold hospital privileges. NPs are required to hold a graduate degree in nursing and national certification to enter into practice in Missouri.

#### Reimbursement

Current law states, "Any health insurer, nonprofit health service plan, or HMO shall reimburse a claim for services provided by an APRN, if such services are within the SOP of such a nurse." Medicaid reimbursement is made to APRNs enrolled as Missouri Medicaid fee-for-service providers and Medicaid-enrolled APRNs associated with a federally qualified healthcare or rural healthcare facility or both.

Medicaid reimbursement is limited to services furnished by enrolled APRNs who are within the SOP allowed by federal and state laws and inpatient or outpatient hospital/clinical services furnished to the extent permitted by the facility. Reimbursement for services provided by APRNs is at the same rate and subject to the same limitations as physicians.

#### Prescriptive authority

Rx authority for CNPs, CNSs, and CNMs includes prescription drugs/devices and Schedules III-V controlled substances as delegated by a physician pursuant to a written CP arrangement. APRNs with a CP arrangement and controlled substance Rx authority are authorized to prescribe hydrocodone-containing compounds from Schedule II controlled substances.

CNPs, CNSs, and CNMs must complete 1,000 hours of postgraduate clinical experience in the APRN role prior to application for controlled substance authority. CRNAs have Rx authority but are prohibited from prescribing controlled substances. Hydrocodone-containing Schedule II and all Schedule III opioid prescriptions will be limited to a 120-hour supply with no refills.

Delivery of such APRN healthcare services shall be within the APRN's advanced clinical nursing specialty area and a mutual SOP with the physician in addition to being consistent with the individual's skill, training, education, and competence. APRNs may receive/dispense samples within their Rx authority. A state Bureau of Narcotics and Dangerous Drugs number, as well as a DEA number, is required. Prescriptions written by an NP are

labeled with both the collaborating physician's and NP's names.

# Montana

www.bsd.dli.mt.gov/license/bsd\_boards/ nur\_board/board\_page.asp www.mtnurses.org/Main-Menu-Category/ About-MNA/Advanced-Practice/CAP www.campaignforaction.org/state/montana

#### Legal authority

The Montana BON grants APRNs authority to practice and regulates their practice. APRNs include CNP, CNS, CNM, and CRNA roles. APRNs practice independently after completing specific curriculum requirements and a national certifying exam by a BON-recognized national certifying body. According to the Montana BON, all APRNs are expected to engage in ongoing competence development per Rule ARM 24.159.1469. APRN SOP is defined in Rule ARM 24.159.1405 and 24.159.1406. APRNs are legally authorized to admit patients and hold hospital privileges; however, this varies according to the rules and bylaws of each hospital.

APRNs licensed after 2008 must have a graduate-level degree or postgraduate certificate from an accredited APRN program and hold national certification to enter into practice. APRNs seeking licensure by endorsement from another state must hold national certification among other requirements. All APRNs must maintain a quality assurance plan as part of the APRN competence development as defined.

#### Reimbursement

Medicaid reimburses APRNs at 85% of physician payment. Montana law requires indemnity plans to reimburse APRNs for all areas and services for which a policy would reimburse a physician; however, HMOs are not included in the indemnity insurers' law, and mandatory coverage for APRNs does not apply to HMOs. APRNs receive 85% of the physician payment from BC/BS. Medicare reimbursement consistent with 1990 federal guidelines is in effect. APRNs are included as providers for workers' compensation.

#### Prescriptive authority

APRNs who desire Rx authority must apply for recognition by the BON. APRNs with Rx authority are independently authorized to prescribe all medications, including Schedules II-V controlled substances using their own DEA number and are permitted to request, receive, and dispense drug samples. Renewal of Rx authority occurs every 2 years,

including an affirmation of a minimum of 12 contact hours of accredited education in pharmacology, pharmacotherapeutics, and/ or clinical management of drug therapy.

### Nebraska

http://dhhs.ne.gov/publichealth/pages/ crlNursingHome.aspx www.nebraskanp.org

www.campaignforaction.org/state/nebraska

#### Legal authority

The Nebraska APRN Board grants APRNs the authority to practice and regulates their practice. APRNs include CNP (NP in statute), CNS, CNM, and CRNA roles. NPs enjoy FPA following a 2,000-hour transition to practice period supervised by an experienced physician or NP, as defined.

An NP's SOP is defined in statute and includes illness prevention, diagnosis, treatment, and management of common health problems and acute and chronic conditions. CNMs continue to practice in collaboration with physicians as specified within the integrated practice agreement (IPA).

CRNAs are authorized to determine and administer total anesthesia care as described in consultation and collaboration with a licensed physician or osteopathic physician. An IPA is not required for CRNA practice. CNS SOP is defined in statute and includes health promotion and supervision, illness prevention, and disease management within a selected clinical specialty. Nebraska requires a master's or doctorate degree in nursing, proof of professional liability insurance, and national board certification to enter practice.

#### Reimbursement

State legislation mandating third-party reimbursement for NPs does not exist; consequently, some NPs have been refused recognition as providers. In 2008, BC/BS began reimbursing APRNs at 85% of the physician rate. Medicaid reimburses NPs at 100% of the physician rate. Legislation passed in 2016 authorizes board-certified primary care NPs or those NPs who specialize in family practice, internal medicine, or pediatrics to be listed as a Direct Provider and be reimbursed for services under the Direct Primary Care Agreement Act.

#### Prescriptive authority

Nebraska NPs are authorized full Rx authority, including Schedules II-V controlled substances as defined in their statute. NPs may request, receive, and dispense pharmaceutical samples if the samples are

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drugs within their prescribing authority. CRNAs prescribe within their specialty practice, and authority is implied in the statute. Qualified CRNAs, NPs, and CNMs may register for a DEA number. CNSs do not have Rx authority in Nebraska.

### Nevada

www.nevadanursingboard.org www.nvnurses.org www.campaignforaction.org/state/nevada www.nonl.org

#### Legal authority

The Nevada BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP (NP in statute), CNS, CNM, and CRNA roles. APRNs who have been practicing for 2 years (or 2,000 hours) are granted FPA. New graduates or those practicing for less than 2 years (or 2,000 hours) are required to complete a transition to practice period, which includes a formal, written collaborative agreement with a physician with written protocols (only if Schedule II controlled substances are prescribed).

APRN SOP is defined in the NPA and includes the nationally established scope and standards for the APRN role and global signature authority. APRNs are not recognized as PCPs under state law; however, they are legally authorized to admit patients to the hospital and hold hospital privileges. If the applicant completed an APRN program after June 1, 2005, the applicant must hold a master's degree in nursing. Applicants requesting APRN licensure after July 14, 2014, must hold a master's or doctorate degree in nursing or related health field and must hold national certification.

#### Reimbursement

APRNs are recognized by insurance companies and receive third-party reimbursement.

#### Prescriptive authority

BON-authorized APRNs may prescribe Schedules II-V controlled substances, poisons, and dangerous drugs and devices when authorized by the BON and a certificate of registration is obtained from the BOP. A collaborative agreement and protocols with a physician are only required for APRNs with less than 2 years or 2,000 hours of experience and only if prescribing Schedule II controlled

APRNs register for their own DEA numbers. APRNs may pass a BON exam for dispensing and, after passing the exam with BON approval, apply to the BOP for a

dispensing certificate. Samples are not considered "dispensing," and APRNs with Rx authority may receive and distribute samples without having dispensing authority.

# New Hampshire

www.state.nh.us/nursing http://nhnpa.enpnetwork.com www.campaignforaction.org/state/newhampshire

#### Legal authority

The New Hampshire BON grants APRNs authority to practice and regulates their practice. APRNs include CNP, CNM, and CRNA roles. APRNs have FPA with their SOP defined in statute and do not require physician collaboration or supervision. APRNs are statutorily recognized as PCPs in New Hampshire: however, state law does not include "any willing provider" language. APRNs may admit patients and hold hospital privileges per individual institutional policy. The minimum academic degree required to enter into practice is a master's degree in nursing, and national certification by a BON-recognized certification agency is required.

#### Reimbursement

All major insurance companies, hospital service corporations, medical service corporations, and nonprofit health service corporations must reimburse APRNs when the insurance policy provides any service that may be legally performed by the APRN and such service is rendered. APRNs are recognized as PCPs by all HMOs in the state. Medicaid reimburses APRNs at 100% of physician payment.

#### Prescriptive authority

BON-licensed APRNs have plenary authority to possess, compound, prescribe, administer, dispense, and distribute controlled and noncontrolled medications within the scope of the APRN's practice. APRNs are assigned a DEA number on request and are authorized to request, receive, and dispense pharmaceutical samples.

The passage of legislation in 2016 requires all prescribers who possess DEA registration to register with the Prescription Drug Monitoring Program and shall complete and submit verification of 3 contact hours (of the 5 that are already required for renewal and reinstatement) of regulatory boardapproved online CE or pass an online exam in the area of pain management, opioid prescribing, addiction disorder, or a combination, as a condition for initial licensure and license renewal or reinstatement. Prescription labels are marked with the APRN's name.

# New Jersey

www.njsna.org

www.campaignforaction.org/state/new-jersey

#### Legal authority

The New Jersey BON grants ARPNs authority to practice and regulates their practice. APRNs are defined as APNs in the state of New Jersey and include CNP, CNS, and CRNA roles. APNs practice in collaboration with physicians and are required to have a joint protocol with the collaborating physician for prescribing drugs and devices only. SOP for APNs is defined in statute. APNs are recognized as PCPs.

However, New Jersey does not have "any willing provider" language in statute. APNs are legally authorized to admit patients and hold hospital privileges, but this is not defined by statute or regulation. Privileges are determined through the credentialing/ privileging process of individual healthcare institutions. APN applicants must be masters' prepared in nursing, and national board certification is required to enter into practice in New Jersey.

#### Reimbursement

Private health plans, including Medicaid managed-care plans, are permitted to credential APNs as PCPs but not required to recognize or reimburse them. Once the APN has been credentialed by or has obtained a provider number from these insurers, the APN is recognized as an Independently Licensed Practitioner/Provider (ILP) and can be directly reimbursed by Medicare, New Jersey Medicaid, New Jersey FamilyCare, United Healthcare, and other Medicaid HMOs, including Cigna, Great West, Health Net, Amerigroup/Choice, QualCare, and Oxford.

Aetna and Horizon BC/BS and some other Horizon MCOs will only credential and reimburse APNs who work in physician practices—not as ILPs providing primary care. Both Horizon and Aetna have fairly consistently credentialed and directly reimbursed Psychiatric APNs. Note that direct reimbursement to APNs is also provided by the Civilian Health and Medical Program (uniformed service members and their families). Where APNs are credentialed and directly reimbursed by private insurers, it is generally at 85% of the physician rate, mirroring Medicare.

#### Prescriptive authority

APNs credentialed by the BON have full Rx authority, including Schedules II-V controlled substances in accordance with a joint protocol, which has been established by the APN and the collaborating physician. The joint protocol is required for prescribing drugs and devices only and is not a collaborative agreement for general practice.

To prescribe controlled substances, APNs must have both a state-controlled dangerous substance (CDS) number/federal DEA number and have modified the joint protocol to indicate whether or not prior consultation with the collaborating physician is necessary before initiating CDS prescriptions. All APNs in New Jersey must complete a one-time, 6-hour course in controlled substance prescribing. APNs are authorized to request, receive, and dispense pharmaceutical samples.

### New Mexico

www.nmna.org www.nmnpc.org

www.campaignforaction.org/state/new-mexico

#### Legal authority

The New Mexico BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP, CNS, and CRNA roles. CNPs practice independently without physician supervision or collaboration requirements and their SOP is defined in statute 61.3.23.2 of Chapter 61, Article 3 of the New Mexico Statutes. APRNs are statutorily recognized as PCPs when providing care within their scope of practice in several areas of New Mexico law; however, New Mexico does not have "any willing provider" language contained within the statutes. CNPs are legally authorized to hold admitting and hospital privileges and can serve as "acute, chronic, long-term, and end-of-life healthcare providers." A master's degree in nursing or higher and national board certification are required to enter into practice as a CNP.

CRNAs seeking initial licensure must be at the master's level or higher. CRNAs work in collaboration with a physician and have Rx authority, including Schedules II-V controlled substances. CNSs must be masters' prepared and certified by a national certifying nursing organization. CNSs "make independent decisions," have "Rx authority," including Schedules II-V controlled substances, and can distribute prepackaged drugs. CNMs are regulated by the Department of Health and are recognized as PCPs in statute.

#### Reimbursement

Statutory authority for third-party reimbursement for NPs and CNSs has been in effect since 1987; however, reimbursement is not legally mandated for CNP services, and CNPs continue to meet resistance in being listed as

PCPs with some companies. FNPs and PNPs receive Medicaid reimbursement at 85% of the physician payment. All three of the managed-care groups contracted to provide Medicaid coverage have contracts with NPs.

#### Prescriptive authority

CNPs have full, independent Rx authority, including Schedules II-V controlled substances. BON prerequisites to prescribe controlled substances include experience with Rx writing, a state-controlled substance license, and a DEA number. Each CNP must maintain a formulary. CNSs must have graduate-level pharmacology, pathophysiology, a physical assessment course, and prescribe in collaboration with a physician, CNP, or CNS with Rx authority during a 400-hour preceptorship before they can prescribe independently.

CNMs have Rx authority pursuant to the rule-making authority of the Department of Health. CRNAs who meet Rx authority requirements may collaborate independently and prescribe/administer therapeutic measures, including dangerous drugs and controlled substances within emergency procedures, perioperative care, or perinatal care environments. CNPs and CNSs with Rx authority may distribute dangerous drugs and Schedules II-V controlled substances that have been prepared, packaged, or prepackaged by a pharmacist or pharmaceutical company. Prescription labels are marked with the APRN's name where appropriate.

### New York

www.nysed.gov

www.campaignforaction.org/state/new-york

#### Legal authority

The New York State Education Department grants CNP (NP in statute) authority to practice and regulates their practice pursuant to Title VIII, Article 139 of NYS Education Law. The term *advanced practice registered nurse* is not defined in New York statutes or regulation. NPs and CNSs are licensed as RNs by the BON and certified by the state education department.

Effective January 2015, NPs who have practiced more than 3,600 hours are no longer required to hold a collaborative practice agreement with a physician; however, NPs with greater than 3,600 hours of practice must attest to a collaborative relationship with a physician. NPs who have not practiced a minimum of 3,600 hours are legally required to practice in collaboration with physicians in accordance with a written practice agreement and written practice protocols until they complete this transition to practice period.

The written practice agreement must include a provision for dispute resolution between the NP and the physician and provisions for a review by the collaborating physician of a patient record sample at least every 3 months. NPs are legally authorized to hold admitting privileges. A master's degree in nursing is required to enter into practice; however, national board certification is not required. CNMs are not regulated or recognized by the BON but must complete a master's or higher degree program in midwifery or a related field that is accredited by the American College of Nurse Midwives Division of Accreditation.

#### Reimbursement

NPs of all specialties may register as Medicaid providers so long as the collaborating physician is also a Medicaid provider (including mental health NPs) and be reimbursed at 100% of the physician rate when billed under the physician provider, and 85% of the physician rate when billed directly as an NP provider. Nurses continue to be qualified providers, and NPs are specifically mentioned as qualified "primary care gatekeepers." A law regulates the practice of HMOs: Provisions are providerneutral and apply equally to physician and nonphysician providers.

Although there is no guarantee that APNs will have a role in managed-care delivery, their rights are assured. The law also prohibits "gagging" healthcare providers; establishes due process for termination of provider contracts; allows for access to specialty providers; includes continuity of care provisions for ongoing care with providers outside of the plan; and requires the commissioner of health to determine that there are sufficient providers to meet the covered patients' needs.

"Willing provider" legislation has been proposed; the public health law would specify "No HMO shall discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing, capable, and can meet the terms and conditions for participation." NPs are included in the New York State Health Insurance Program Empire Plan (insures 122,000 New York state employees and their families) offered by the two largest state employees' unions.

#### Prescriptive authority

NPs are eligible for full Rx authority, including Schedules II-V controlled substances, following completion of required coursework in pharmacotherapeutics, prescription writing, and record keeping. NPs may order drugs, devices, immunizing agents, tests, and procedures either

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independently if they have completed a minimum of 3,600 hours of practice or in accordance with the written practice agreement and practice protocols during the transition to practice period without physician cosignature.

Legislation passed in 2016 requires providers with DEA registration to complete a Department of Health-approved, 3-hour CE course in pain management, palliative care, and addiction to be completed within 1 year of DEA registration and once every 3 years thereafter. This new CE requirement is included in existing state-law required CE requirements, not in addition to.

NPs may receive and dispense pharmaceutical samples if appropriately labeled and handed directly to the patient. Prescription labels are labeled with the NP's name. Midwives are authorized to prescribe and administer drugs, immunizing agents, diagnostic tests, devices, and order lab tests limited to the practice of midwifery; they can dispense pharmaceutical samples packaged or prepackaged by a pharmacist or pharmaceutical company.

### North Carolina

www.ncnurses.org www.campaignforaction.org/state/northcarolina

#### Legal authority

A Joint Subcommittee of the North Carolina BON and the North Carolina Medical Board grant CNPs the authority to practice and regulate their practice. CRNAs and CNSs are regulated solely by the BON, and CNMs are regulated by the Midwifery Joint Committee. APRNs include CNP (NP in statute), CRNA, CNS, and CNM roles, and all APRNs are required to maintain a current unencumbered RN license.

NPs legally practice under a supervisory relationship with a physician, which is operationalized through a written CPA with a physician for continuous availability (not necessarily on-site) along with ongoing supervision, consultation, collaboration, referral, and evaluation.

During the first 6 months of NP practice with a new PCP, monthly meetings are required for the first 6 months, then every 6 months thereafter. These meetings must be documented with NP and physician signatures. The CPA also includes the drugs, devices, medical treatments, tests, and procedures that may be prescribed, ordered, and performed by the NP as well as a plan for emergency services.

State law does not prohibit NPs from having admitting privileges and hospital

privileges; however, these are granted on a facility-by-facility basis. Each of the four APRN roles are required to hold a minimum of a master's degree in nursing (or related field depending on the role) and must be nationally certified to enter into practice. APRNs are authorized to form corporations with physicians; however, CRNAs can only incorporate with anesthesiologists.

#### Reimbursement

NPs/CNMs receive Medicaid reimbursement at 100% of the physician rate for primary care activities. NPs who are enrolled as psychiatric/mental health providers receive 85% of the physician rate. Statutory authority for third-party reimbursement for NPs provides direct reimbursement to NPs for services within their scope. Psychiatric/ mental health CNS services are reimbursable by insurance. CRNA services are reimbursable by insurance.

#### Prescriptive authority

NPs and CNMs have full Rx authority, including Schedules II-V controlled substances that are identified in their CPA. Dispensing may be done under specific conditions and if a dispensing license has been obtained. NPs/CNMs may provide refills consistent with controlled substance laws and regulations, which stipulate that prescriptions for Schedule II controlled substances cannot be refilled. A new prescription must be issued. Adoption of the 2017 Strengthen Opioid Misuse Prevention (STOP) Act limits prescribers to a 5-day supply of any "targeted controlled substance" (G.S. 90-90(1) or (2) or G.S. 90-91(d)) upon initial consultation and treatment for acute pain, and a 5-day supply of any "targeted controlled substance" for postoperative acute pain relief for use following a surgical procedure, with some exceptions.

The STOP Act further requires the NP to consult with a supervising physician prior to prescribing some certain Schedule II and Schedule III controlled substances labeled "targeted controlled substances" in a pain management clinic or where pain management services are advertised when use of the targeted controlled substance is expected to exceed 30 days. NPs must consult with the physician at least once every 90 days thereafter.

NPs and CNMs with controlled substances in their collaborative practice agreements must obtain DEA registration (in addition to their approval number issued at the time of their approval as NPs/CNMs) and the supervising physician(s) shall possess the same schedule(s) of controlled substances as the NP's DEA registration. NPs are authorized to hand out, free of any charge, starter doses or packets of prescription drug samples received from a prescription drug manufacturer in compliance with the Prescription Drug Marketing Act. CRNAs and CNSs do not have Rx authority in North Carolina.

### North Dakota

www.ndbon.org www.ndnpa.org www.campaignforaction.org/state/north-dakota www.ndna.org

#### Legal authority

The North Dakota BON grants APRNs the authority to practice and regulates their practice. Individuals are licensed as APRNs in one of four roles: CNP, CNS, CNM, or CRNA. APRNs practice independently in North Dakota, and their SOP is defined in regulation and must be consistent with their nursing education and certification. APRN applicants for initial licensure must have a graduate degree with a nursing focus or have completed educational requirements in effect when the applicant was initially licensed as well as hold national certification in an advanced nursing role.

#### Reimbursement

FNPs, PNPs, and CNMs receive Medicaid reimbursement at 75% of the physician rate and CNMs at 85% of the physician rate. BC/ BS reimburses CRNAs, CNMs, CNSs, and NPs based on the lesser of the provider's billed charges or 75% of the BC/BS physician payment system in effect at the time the services are rendered. Legislation passed in 2009 granted an NP authority to be a PCP within the Medicaid system. Any certified NP is eligible for a Medicaid provider number. State law authorizes reimbursement for health services provided in the scope of licensure by nurses with advanced licensure and mental health in their SOP. APRNs are statutorily recognized as PCPs. Providers practicing more than 20 miles from Williston, Dickson, Minot, Bismarck, Jamestown, Devils Lake, Grand Forks, Wahpeton, and Fargo shall be reimbursed the lesser of provider's billed charges or 85% of the BC/BS physician payment system(s) in effect at the time services are rendered.

#### Prescriptive authority

Authorized APRNs may prescribe, administer, sign for, and dispense OTC, legend, and controlled substances and procure pharmaceuticals, including sample legend drugs and Schedules II-V controlled substances. For Rx authority, the APRN must submit an application to the BON and meet

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the requirements outlined in North Dakota Administrative Code section 54-05-03.1-09. APRNs with Rx authority may apply for a DEA number.

### Ohio

www.nursing.ohio.gov www.oaapn.org

www.campaignforaction.org/state/ohio

#### Legal authority

The Ohio BON grants APRNs the authority to practice and regulates their practice. The BON issues APRN licenses with the designation of CNP, CRNA, CNM, or CNS. Legal authority to practice requires a CP arrangement between a physician or podiatrist and an APRN-CNP or APRN-CNS, and between a physician and an APRN-CNM in the form of a standard care arrangement (practice agreement). CRNAs are required to practice with a supervising physician. The SOP for CNPs is defined in statute ORC 4723.43. CNPs are statutorily recognized as providing preventive and primary care services, services for acute illnesses, and evaluation and promotion of patient wellness within the nurse's specialty, consistent with the nurse's education and certification.

APRNs are authorized to admit patients to a hospital if the APRN has a standard care arrangement with a collaborating physician who is a member of the medical staff of the hospital. Applicants for APRN licensure must have a master's or doctoral degree in nursing or a related field that qualifies the individual to sit for the national certifying exam and hold national certification to enter into practice.

#### Reimbursement

Ohio's Medicaid program recognizes CNPs certified in family, adult, acute care, geriatric, neonatal, pediatric, and women's health/obstetrics. It also recognizes CNMs, CRNAs, and CNSs certified in gerontology, medical-surgical, and oncology nursing specialties. MCOs vary on empanelment. There are no legislative restrictions for an APN to be listed on managed-care panels; insurance companies are statutorily mandated to reimburse CNMs. Workers' compensation continues to reimburse CNPs, CRNAs, and CNSs. (The BON does not maintain information regarding reimbursement.)

#### Prescriptive authority

Ohio state law includes Rx authority within the APRN license issued to CNPs, CNMs, and CNSs including Schedules II-V controlled substances under rules and in collaboration with a physician. APRN-CNPs, APRN-CNMs, and APRN-CNSs register with the Ohio

Automated Rx Reporting System and access the database information as required.

APRNs prescribe based upon an exclusionary formulary recommended by the Interdisciplinary Committee on Prescriptive Governance and adopted by the BON. APRNs are permitted to prescribe newly released drugs if they are not of a type that is prohibited by the exclusionary formulary. APRNs who wish to prescribe drugs for off-label use must include parameters for off-label use in the standard care arrangement. The prescribing of Schedule II controlled substances is limited to those prescriptions issued from specific locations and programs recognized in Ohio nursing law, and as consistent with the APRN's standard care arrangement. Limitations are also placed on APRNs' prescribing of opioids for the treatment of acute pain.

APRNs who are not practicing in a location or program recognized in law are limited in their Schedule II controlled substance prescribing to the care of terminally ill patients after a physician has initiated and only for a 72-hour period. DEA registration is required.

Prescriptions are labeled with the name of the prescriber. APRNs with Rx authority may request, receive, sign for, and personally furnish sample medications. All samples of medications that are personally furnished by the APRN must be consistent with the APRN's scope and not excluded by state or federal law.

### Oklahoma

www.lsb.state.ok.us www.ok.gov/nursing

www.campaignforaction.org/state/oklahoma

#### Legal authority

The Oklahoma BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP, CNS, CNM, and CRNA roles. CNPs function independently with the exception of Rx authority, which requires supervision by a physician. APRNs practice within an SOP as defined by the NPA. The SOP for a CNP is further identified in specialty categories that delineate the population served, such as adult gerontology, family/individual across the lifespan, and so forth. CNSs must hold a master's degree in nursing, and CNPs/CNSs must be nationally board certified to enter into practice.

The CRNA functions under the supervision of a medical physician, DO, podiatric physician, or dentist licensed in Oklahoma and under conditions in which timely, on-site consultation by such medical physician, DO, podiatric physician, or dentist

is available. Effective January 1, 2016, APRN applicants must have completed an accredited graduate-level APRN education program in at least one of the following population foci: family/individual across the lifespan, adult gerontology, neonatal, pediatrics, women's health/gender-related, or psychiatric/mental health.

#### Reimbursement

Oklahoma's Medicaid plan includes CNPs as primary care managers. State law does not mandate reimbursement of CNPs; however, the Oklahoma State and Education Employees Insurance Company recognizes CNPs as providers. Negotiation continues with other third-party insurers.

#### Prescriptive authority

The BON regulates optional Rx authority for CNPs, CNSs, and CNMs, which includes Schedules III-V controlled substances. Physician supervision is required for the Rx authority. Prescribing parameters include the following: must not be on the exclusionary formulary approved by the BON; must be within the CNP, CNM, and CNS SOP; include Schedules III-V controlled substances (30-day supply) if state Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) and DEA registrations are obtained; and include signing to receive drug samples. A CRNA, regulated by the BON, may order, select, obtain, and administer drugs only during the perioperative or periobstetrical period. CRNAs must obtain state OBNDD and DEA registrations to order Schedules II-V controlled substances.

# Oregon

www.oregonrn.org www.oregon.gov/OSBN

www.campaignforaction.org/state/oregon

#### Legal authority

The Oregon BON grants FPA to and regulates CNPs (NP title in regulation; CNMs are a category of NP), CNSs, and CRNAs. Nurses in all three categories of advanced practice must be credentialed with a certificate by the BON. "APRN" is not a protected title in the Oregon NPA. SOP is defined in regulation, Division 50, 52, and 54 of the NPA and NPs are statutorily recognized as PCPs, and permissive statutes allow for NP hospital privileges.

NPs may, however, be refused privileges only on the same basis as other providers. A master's degree in nursing or a doctoral degree in nursing is required for the CNS entry into practice and is also required for the NP or CRNA educated after specific dates (see regulations for further information). Since 2011, national board certification has been

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required to enter into practice. Only physicians can authorize medical marijuana use.

#### Reimbursement

NPs are entitled by law to reimbursement by third-party payers. APRNs are designated as PCPs on several HMO and managed-care plans. Medicaid reimburses NPs for services within their SOP at the same rate as physicians. Statutory authority provides full payment parity from private insurers for NPs in independent practice and when billing through a clinic or practice. Numerous administrative rules and statutes include NPs, such as special education physical exams (Department of Education) and chronically ill and disabled motorist exams (Department of Motor Vehicles).

#### Prescriptive authority

Regulation of Rx authority is under the sole authority of the BON and is defined in Division 56 of the NPA. Oregon has legislated independent or plenary authority for NPs and CNSs to prescribe, so NPs and CNSs are able to obtain DEA numbers for Schedules II-V controlled substances. NPs and CNSs with prescription-writing authority may receive and distribute prepackaged complementary drug samples. NPs and CNSs may apply to the BON for unencumbered drug-dispensing authority. NPs do not have authority to prescribe under the physician-assisted suicide law.

CRNAs are authorized to select, obtain, order, and administer preanesthetic medications, anesthetic agents, and medications necessary for implementing and managing pain management techniques during the postanesthesia period pursuant to ORS 851-052-0010. CRNAs may apply to the BON for limited Rx authority.

# Pennsylvania

www.dos.pa.gov/ProfessionalLicensing/ BoardsCommissions/Nursing/Pages/default.aspx www.pacnp.org

www.campaignforaction.org/state/Pennsylvania

#### Legal authority

The Pennsylvania BON grants CRNPs and CNSs authority to practice and regulates their practice. "APRN" is not defined in statute or regulation. A CRNP performs the expanded role in collaboration with a physician, which is defined as a process in which a CRNP works with one or more physicians to deliver healthcare services within the scope of the CRNP's expertise. The CRNP's SOP is defined in statute and regulation. CRNPs are recognized as PCPs by the DPW and many insurance companies, but some managed-care companies do not recognize CRNPs as PCPs.

The Pennsylvania Department of Health Regulations authorizes a hospital's governing body to grant and define the scope of clinical privileges to individuals with advice of the medical staff. After February 5, 2005, CRNPs must have a master's degree and pass a national certification exam. The BON does not track, monitor, or license CRNAs; the BOM licenses and regulates CNMs.

#### Reimbursement

Third-party reimbursement is available for the CRNP, CRNA, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric/mental health nurse, and certified CNS, provided the nurse is certified by a state or a national nursing organization recognized by the BON. Medicaid reimburses CRNPs and CNMs at 100% of the physician payment for certain services. The State Department of Health allows HMOs to recognize CRNPs as primary care gatekeepers.

#### Prescriptive authority

The BON confers Rx authority, including Schedules II-V controlled substances, to CRNPs with a collaborating physician. Regulations allow a CRNP to prescribe and dispense drugs if the CRNP has successfully completed a minimum of 45 hours of course work specific to advanced pharmacology and if the prescribing and dispensing is relevant to the CRNP's area of practice, documented in a collaborative agreement, not from a prohibited drug category, and conforms with regulations. The CRNP may write a prescription for a Schedule II controlled substance for up to a 30-day supply.

CRNPs may prescribe Schedules III-IV controlled substances for up to a 90-day supply; Schedule V is not restricted. CRNPs are authorized to request, receive, and dispense pharmaceutical sample medications. Prescription blanks must include the name, title, and Pennsylvania certification number of the CRNP. The collaborative agreement is a signed, written agreement between the CRNP and a collaborating physician in which they agree to the details of their collaboration, including the elements in the definition of collaboration.

### Rhode Island

www.health.ri.gov/for/nurses http://npari.enpnetwork.com www.campaignforaction.org/state/rhode-island

#### Legal authority

The Rhode Island BON grants APRNs FPA and regulates their practice. APRNs include CNP, CNS, and CRNA roles. CNMs are licensed and regulated under separate R&Rs and not regulated by the BON. SOP is defined within the NPA. CNPs are statutorily recognized as PCPs in Rhode Island by the Medicaid managed-care program.

Nothing prohibits hospitals from granting admitting and hospital privileges to providers; however, privileging is granted by the facilities based upon individual policies. APRNs are considered licensed independent practitioners in this state. The minimum degree to enter into practice for all APRNs is completion of a graduate or postgraduatelevel APRN program and national board certification (certain exceptions apply).

#### Reimbursement

State law allows for direct reimbursement of PCNSs and CNMs. PCNSs practicing in collaboration with or employed by a physician receive third-party reimbursement; there is no collaborative or supervisory language in the statute as it pertains to CNPs. United Healthcare has begun to empanel NPs, and the Neighborhood Health Plan fully empanels CNPs as PCPs. The RiteCare Program (managed-care program for persons eligible for Medicaid) allows CNPs and CNMs to serve as PCPs. CRNAs receive third-party reimbursement for services under the supervision of anesthesiologists or dentists.

#### Prescriptive authority

With the passage of S614 in 2013, APRNs are granted independent Rx authority, including authority to prescribe, order, procure, administer, dispense, and furnish OTC, legend, and controlled substances (General Laws in Chapter 5-34, Section 5-34-49) within their APRN role and population focus. CNPs may also be authorized to apply for Schedules II-V controlled substances. CRNA, CNS, and APRNs in mental health prescribe pursuant to Chapter 5-34, Section 5-34-49 (e), (f), and (g).

### South Carolina

www.llr.state.sc.us/pol/nursing www.scnurses.org

www.campaignforaction.org/state/south-carolina

#### Legal authority

The South Carolina BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP, CNS, CNM, and CRNA roles. APRNs must have a collaborative relationship with a physician and may perform "delegated medical acts" in addition to nursing acts as defined by the BON. Delegated medical acts may be performed by NPs, CNSs, and CNMs pursuant to an approved written protocol between the nurse and physician and are defined as "additional acts delegated by the physician that include formulating a medical diagnosis and

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initiating, continuing, and modifying therapies, including prescribing drug therapy under approved written protocols."

NPs, CNSs, and CNMs who manage delegated medical aspects of care must have a supervising physician who can be accessed by electronic/telephonic means and operate within the "approved written protocols." APRNs are legally authorized to admit patients to a hospital and hold hospital privileges; however, this is left up to the individual agency. APRNs must hold a doctorate, postmaster's certificate, or a minimum of a master's degree in nursing and national board certification in an advanced practice nursing specialty to enter into practice.

#### ■ Reimbursement

All NPs, regardless of specialty, may apply for a National Provider Identifier (NPI) number, are paid 85% of the physician rate, and are recognized as PCPs. The State Health and Human Services Finance Commissioner requires that NPs have current, accurate, and detailed treatment plans. Approximately 23 payers recognize, enroll, and directly reimburse APRNs for services provided. Dr. Stephanie Burgess is the first APRN to sit on the advisory board for State Health and Human Services Board in South Carolina, while the rest of the Board consists of MDs.

#### Prescriptive authority

NPs, CNSs, and CNMs have Rx authority, including Schedules III-V controlled substances, and prescribe according to practice agreement/protocol within the specialty area of the APRN. CRNAs are not required to obtain Rx authority to deliver anesthesia care; however, CRNAs practice pursuant to approved written guidelines with a supervising physician, dentist, or medical staff. The BON issues an ID number to the nurse authorized to prescribe. State law requires prescriptions by NPs be signed by the NP, contain the NP's BON-assigned Rx authority number and place of practice, and the physician's name and address preprinted on the prescription blank.

APRNs with Rx authority may request, receive, and sign for professional samples, including Schedules III-V controlled substances.

### South Dakota

http://doh.sd.gov/Boards/Nursing www.npasd.org

www.campaignforaction.org/state/south-dakota

#### Legal authority

South Dakota recognizes the title APRN and the four roles: CNP, CNS, CNM, and CRNA.

The state adopted new licensure and practice laws for CNMs and CNPs following the 2017 legislative session. Major changes to the practice act included removing collaborative agreement requirements, placing the regulation of CNMs and CNPs under the sole jurisdiction of the BON, and modernizing statutory language. As a result, the BON is responsible for licensing, determining practice, and disciplinary functions of APRNs.

CNMs and CNPs practice full scope without a collaborative agreement after verifying completion of a minimum of 1,040 hours of practice as a licensed CNM or CNP. Nurses who cannot verify licensed practice hours are required to submit a collaborative agreement with a South Dakota licensed physician, CNM, or CNP to meet the requirement; once the minimum hours are met, the collaborative agreement is retired.

CRNAs and CNSs are required to collaborate with a physician; no written agreement or on-site supervision is required. CRNAs and CNSs do not have Rx authority, and CNSs must collaborate before ordering durable medical equipment or therapeutic devices. All APRNs may be granted hospital privileges.

APRN licensure requirements include holding an unencumbered South Dakota RN license or multistate privilege to practice, a graduate degree in nursing, and national certification within role and population foci; certain exemptions are allowed.

#### Reimbursement

CNPs and CNMs receive Medicaid reimbursement at 90% of the physician rate. CRNAs are reimbursed at the physician rate for services provided under Medicaid. State insurance law is silent regarding CNSs; however, CNSs may be reimbursed under specific plans. Medicaid reimbursement is allowed only if billed through a physician's practice. CNPs and CNMs receive third-party reimbursement.

State law mandates that CRNAs, CNPs, and CNMs must be reimbursed on the same basis as other medical providers, assuming that the service is covered under the policy; CRNAs, CNPs, and CNMs may receive reimbursement when the service is covered under the policy and they are acting within their SOP.

#### Prescriptive authority

South Dakota's CNPs and CNMs may prescribe legend drugs and Schedules II-IV controlled substances. CNPs and CNMs have two controlled substance registration options: They may seek independent state registration and independent DEA registration in all schedules, or they may act as an

agent of an institution, using the institution's registration number to prescribe, provide, or administer controlled substances. Controlled substance authority is granted by separate application to the South Dakota Department of Health.

CNPs and CNMs may request and receive drug samples, provide drug samples, and provide a limited supply of labeled medications. Medications and sample drugs must be accompanied by written administration instructions and documentation entered in the patient's medical record. The provision of drug samples or a limited supply of medications is not restricted, and the amount provided is at the professional discretion of the CNM or CNP. CNPs or CNMs who accept controlled substances, either trade packages or samples, must maintain a record of receipt and disposition as required by the DEA. CRNAs and CNSs do not have Rx authority; however, CNSs may order and dispense durable medical equipment and therapeutic devices in collaboration with a physician.

### Tennessee

www.tnaonline.org www.tn.gov/health

www.campaignforaction.org/state/tennessee

#### Legal authority

The Tennessee BON grants APRNs authority to practice via a license and regulates their practice. APRNs are defined in regulation and include CNP (NP in regulation), CNS, CNM, and CRNA roles. APRNs meeting requirements for Rx authority are eligible for a certificate that is designated "with certificate to prescribe."

APRNs must hold a current RN license in Tennessee or a compact state if their home state is a compact state. APRNs who prescribe must have protocols that are jointly developed by the APRN and a collaborating physician. Medical Board rules that govern the collaborating physician of the APRN prescriber are jointly adopted by the BOM and RON

Physicians who collaborate with APRN prescribers are not required to be on-site but must personally review and sign 20% of the charts within 30 days; physicians are authorized to review charts electronically when the APRN is working in a free or reduced-fee clinic. CRNAs and CNMs are defined in the hospital licensure rules, which also provide that the medical staff may include CNMs; CNMs are not precluded from admitting a patient with the concurrence of a physician member of the staff.

NPs have admitting and clinical privileges in Medicare critical access hospitals; however, privileges for NPs are not

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addressed in other hospital licensure rules, and these privileges are inconsistent across the state. APRNs are required to hold a master's degree or higher in a nursing specialty and national certification to enter into practice in this state.

#### Reimbursement

Tennessee's private insurance laws mandate reimbursement of APRNs. A managed-care antidiscrimination law prevents MCO discrimination against APRNs (specifically CNPs, CNSs, CNMs, and CRNAs) as a class of providers. However, not all organizations are, as of yet, credentialing and accepting APNs into their network. This is a major issue being addressed by the Tennessee Nurses Association and private APRN practice

BC/BS credentials APRNs in most of their programs and provides 100% reimbursement to primary care NPs in the TennCare program; BC/BS also reimburses CNMs and CRNAs. Other MCOs participating in the TennCare program also credential APRNs and assign an established patient panel upon individual review of specialty.

#### Prescriptive authority

APRNs who have a BON-issued certificate to prescribe may prescribe legend and Schedules II-V controlled substances pursuant to protocols. Preauthorization is required for off-formulary medications and for Schedules II or III opioid prescriptions of more than a 30-day supply. Prescribers must also confer with the controlled substance database prior to issuing a prescription for opioids or benzodiazepines as a new course of treatment that will last more than 7 days and at least annually when the controlled substance medication remains part of ongoing treatment.

Both the collaborating physician's name and address must be printed on the prescription blank; however, the APRN may sign the prescription. NPs may request, receive, and issue pharmaceutical samples.

### Texas

www.bon.texas.gov www.cnaptexas.org www.texasnp.org www.campaignforaction.org/state/texas

#### Legal authority

The BON is authorized by the NPA to regulate APRNs who are licensed in one or more of the following recognized roles: NP, CNS, CNM, or CRNA. The APRN's SOP is based on advanced practice education, experience, and the accepted SOP of the associated population focus area. The APRN acts

independently and/or in collaboration with the healthcare team.

The authority to make a medical diagnosis and write prescriptions must be delegated by an MD or DO using written delegation protocols or other written authorization in addition to a Rx authority agreement detailing those drugs and devices, which may be ordered or prescribed by the APRN. These two documents may be combined into a comprehensive document providing authority for both diagnosing and prescribing or ordering.

The rules define protocols as written authorization to provide medical aspects of care. Protocols allow the APRN to exercise professional judgment and are not required to outline specific steps the APRN must take, but they are required to contain certain elements regarding Rx authority. Hospitals may extend privileges to APRNs but are not required to do so. Hospitals electing to extend clinical privileges to APRNs must use a standard application form and afford due process rights in granting, modifying, or revoking those privileges. APRNs are recognized and may contract as PCPs in managed-care organizations.

#### Reimbursement

All APRN categories are eligible for direct Medicaid reimbursement at 92% of the physician rate. Under certain circumstances, physicians in the Texas Medicaid Program may bill for an APRN's services and receive 100% of the physician rate. Some programs, such as Texas Health Steps, reimburse all providers at the same rate. APRNs are listed in the Texas Insurance Code as practitioners who must be reimbursed by indemnity health insurance plans. All HMOs and PPOs in Texas must list an APRN on provider panels if the APRN's collaborating physician is on the panel and the physician requests that the APRN also be listed.

#### Prescriptive authority

APRNs may be delegated Rx authority by a physician, which includes nonprescription, legend, and Schedules II-V controlled substances under certain circumstances contained within 22 Texas Administrative Code \$222. Schedules III-V controlled substances authority may be delegated with the following limitations: APRNs may only prescribe a maximum 90-day supply; APRNs must consult with the physician before authorizing a refill; and ARPNs may not prescribe controlled substances to a child under age 2 years without physician consultation, which must be noted in the chart.

Schedule II controlled substance authority may be delegated to an APRN when prescribing in a hospital-based facility to a patient who has been admitted for a period of 24 hours or greater; is receiving services in the ED; or as part of the plan of care for treatment of a patient receiving hospice care. The ratio of supervision has been increased to 1:7 full-time equivalents (physician to APRNs and/or PAs); however, the supervision ratio does not apply to the Rx authority agreement when Rx authority is delegated in a medically underserved area or a hospital-based facility. APRNs with Rx authority may request, receive, possess, and distribute samples of drugs they are authorized to prescribe.

### Utah

www.dopl.utah.gov/index.html http://utahnp.enpnetwork.com www.campaignforaction.org/state/utah

#### Legal authority

The Utah BON, in collaboration with the Division of Occupational and Professional Licensing, grants authority to practice via licensure with an "APRN" or "APRN-CRNA without prescriptive practice" license and regulates the practice of APRNs and CRNAs, pursuant to the Utah Nurse Practice Act, Part 3, 58-31b-301. Licensed APRN roles include the CNP, CNS, psychiatric/mental health nurse, CNM, and CRNA. CNMs are regulated by a separate practice act and CNM board. APRNs practice independently without physician supervision or collaboration with the exception of Schedules II-III controlled substance authority as described below under Rx authority.

The APRN SOP is defined by set standards from national, professional, and specialty organizations. APRNs are not statutorily prohibited from admitting patients and holding hospital privileges; however, this is decided upon by the individual institution. All APRNs must hold a master's degree or higher and be nationally certified to obtain licensure. Utah legislature was the first to adopt the APRN compact in 2004.

#### Reimbursement

The state insurance code has a nondiscrimination code; nothing prohibits reimbursement. APRNs are reimbursed by most insurance companies. As of April 2014, Medicaid empanels and reimbursed all board-certified NP specialties at 100% of the physician rate. CNMs are reimbursed by Medicare and Medicaid at 100% of the physician rate, whereas other APRN roles receive reimbursement at 80% of the physician rate.

#### Prescriptive authority

APRNs including CNMs have Rx authority for all legend drugs and devices, now including

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Schedules III-V controlled substances within their SOP. A consultation and referral plan is required if prescribing Schedules II or III controlled substances in a pain clinic and if prescribing Schedule II controlled substances in all other settings with some exceptions.

APRNs can prescribe Schedule II controlled substances without a consultation and referral plan in settings other than a pain clinic if they meet experience requirements (have the lesser of 2 years of licensure as an APRN or 2,000 hours of experience as an APRN), the CS Database is consulted and follows prescribing for chronic pain guidelines.

Legislation prohibits an APRN from establishing an independent pain clinic without a consultation and referral plan. APRN-CRNAs do not require a consultation or referral plan for their practice. CRNAs may order and administer drugs, including Schedules II-V controlled substances in a hospital or ambulatory care setting; they may not provide prescriptions to be filled outside the hospital. APRNs, including CNMs and CRNAs, receive a DEA number after passing a controlled substance exam and obtaining a state-controlled substance license; CRNAs may use facility DEA numbers under certain conditions. APRNs and CNMs may sign for and dispense drug samples.

### Vermont

www.sec.state.vt.us/professionalregulation/ professions/nursing.aspx www.vtnpa.org

www.campaignforaction.org/state/vermont

#### Legal authority

The Vermont BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP (NP in regulation), CNS in psychiatric and mental health nursing, CNM, and CRNA roles. APRNs are independent providers after a transition to practice requirement is met (2,400 hours and 2 years) with an SOP defined in statute and regulations. According to agency protocols, APRNs are authorized to admit patients to a hospital and hold hospital privileges. APRNs are required to have a master's degree in nursing and hold national board certification to enter into practice.

#### Reimbursement

BC/BS reimburses psychiatric NPs using a provider number. Although legislation requiring or prohibiting third-party reimbursement does not exist, insurance companies may reimburse NPs depending on policies. Legislation passed in 2017 authorizes reimbursement to APRNs providing telehealth services within and outside of a healthcare facility.

#### Prescriptive authority

APRNs have full Rx authority, including Schedules II-V controlled substances within their practice guidelines. APRNs have the same privileges dispensing and administering drugs as physicians. Legislation passed in 2016 requires prescribers to query the Vermont Prescription Monitoring System when prescribing a new or renewal prescription for an opioid within Schedules II-IV controlled substances and when starting a patient on nonopioid Schedules II-IV controlled substances for nonpalliative long-term pain therapy for more than 90 days. NPs register for their own DEA numbers and are authorized to request, receive, and/or dispense pharmaceutical samples. Prescriptions are labeled with the APRN's name.

# Virginia

www.dhp.virginia.gov www.vcnp.net

www.campaignforaction.org/state/virginia

#### Legal authority

The Virginia BON and BOM have joint statutory authority to regulate licensed NPs (LNPs). LNPs include NP, CNM, and CRNA roles. Legislation passed in 2016 now identifies CNSs as APRNs; however, CNSs are registered solely with the BON and do not have Rx authority. NPs practice in collaboration and consultation with a patient-care team physician as part of a patient-care team. CNMs practice in consultation with a licensed physician in accordance with a practice agreement, and CRNA practice remains under the supervision of a physician.

NP practice is based on education, certification, and a written practice agreement, and NPs are included in the list of professions authorized to perform surgery. According to the Virginia BON, NPs are not statutorily prevented from being PCPs, and no law or regulation prevents them from admitting patients to the hospital and holding hospital privileges. Virginia state law does not include NPs in its "any willing provider" language. A master's degree in nursing and national board certification is required to enter into practice in Virginia. NPs are also authorized to certify medical necessity of durable medical equipment that is to be reimbursed by Medicaid.

#### ■ Reimbursement

Board-certified NPs and CNMs are reimbursed by Medicaid at 100% of the physician rate. PMH NPs are paid the same rate for psychiatric diagnosis, evaluation, and psychotherapy services as a PCNS, which is 67% of the rate currently paid to Medicaid-enrolled psychiatrists. For other procedures,

such as physical exams, PMH NPs are reimbursed at the same rate as other NPs.

NPs can independently bill for services with insurers; however, payment is dependent upon individual company policy. Virginia has an "any willing provider" law, but it applies only to mandated providers and, among APNs, only PCNSs and CNMs are mandated providers. CNMs and CNSs in psychiatric health receive third-party reimbursement.

#### Prescriptive authority

Authorized LNPs may prescribe all legend drugs, including Schedules II-V controlled substances, as defined in the LNP's Practice Agreement. A Practice Agreement, developed between the NP and the patient-care team physician and maintained by the NP (which is to be provided to the Joint Boards of Nursing and Medicine upon request), lists the drug categories the NP will prescribe. NPs may only prescribe legend drugs if "such prescription is authorized by the practice agreement between the NP and physician." The prescription must include the NP's name and Rx authority number.

The name and contact information of the collaborating physician will be provided to the patient upon request. CNMs may prescribe Schedules II-V controlled substances. Physicians who enter into a practice agreement with an LNP may only collaborate at any one time with up to six NPs with Rx authority. Periodic electronic or chart review is required, and physician collaboration and consultation may be satisfied via telemedicine. The collaborating physician is not required to regularly practice at the same site as the NP with Rx authority. A separate practice site may be established.

The joint regulations of the BON and BOM include requirements for continued NP competency, including 8 hours of CE in pharmacology or pharmacotherapeutics for each biennium. LNPs may receive and dispense drug samples under an exemption to the state Drug Control Act, which states that the act "shall not interfere with any LNP with Rx authority receiving and dispensing to his own patients manufacturer's samples of controlled substances and devices that he is authorized to prescribe according to his practice setting and a written agreement with a physician."

# Washington

www.doh.wa.gov/LicensesPermitsandCertificates/ NursingCommission.aspx www.auws.org

www.wsna.org

www.wsna.org

www.campaignforaction.org/state/washington

#### Legal authority

The Nursing Care Quality Assurance Commission grants APRNs the authority to

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practice and regulates their practice; APRNs are designated as ARNPs in statute and regulation, which include NP, CNS, CNM. and CRNA roles. ARNP practice is independent, and ARNPs assume primary responsibility for continuous and comprehensive management of a broad range of patient care, concerns, and problems. ARNP SOP is defined in statute and regulation. ARNPs are statutorily defined as PCPs and are legally authorized to admit patients to a hospital and hold hospital privileges. However, hospitals and medical staff have the right to make the decision on credentialing. A graduate degree and national certification are required to obtain licensure as an ARNP in Washington.

#### Reimbursement

Medicaid reimbursement is available to ARNPs at 100% of the physician rate. Labor and Industries reimbursement was increased in 2016 by rule from 90% to 100% of the physician rate. Current rulemaking proposes to increase reimbursement to 100%. The Healthcare Service Contracts Act (RCW 48.44.290) makes it illegal to deny a healthcare service performed by an RN or ARNP within the person's SOP if the healthcare contract would have approved the same service performed by a physician.

A court ruled that the law's use of the term "healthcare service contract" referred to contracts between the health plan and the insured individual and did not extend to the healthcare provider. The court ruled that the law did not have legal force in addressing reimbursement parity for ARNPs because it only applied to the agreement between the health plan and the patient. Consequently, many private insurance companies reimburse ARNPs at a lower rate than a physician for the same service.

#### Prescriptive authority

All ARNPs who receive Rx authority may independently prescribe legend drugs and Schedules II-V controlled substances. Independent Rx authority requires an initial 30 contact hours of education in pharmacotherapeutics (within the applicant's SOP) obtained within the 2-year period immediately prior to application. An advanced pharmacology course, taken as a part of the graduate program, meets the requirement if the application is made within 2 years of graduation. Renewal of Rx authority every 2 vears requires 15 hours of pharmacotherapeutic education within the area of practice. ARNPs are legally authorized to request, receive, and dispense pharmaceutical samples, and prescriptions are labeled with the ARNP's name.

# West Virginia

www.wvrnboard.com

www.campaignforaction.org/state/west-virginia

#### Legal authority

The West Virginia BON grants authority to practice and regulates the practice of APRNs; law defines advanced practice for RNs. APRNs include CNP, CNS, CNM, and CRNA roles. APRN SOP includes the autonomous ability to assess, conceptualize, diagnose, analyze, plan, implement, and evaluate complex problems related to health autonomously. CRNAs administer anesthesia in the presence and under the supervision of a physician or doctor of dental surgery. Hospital credentialing for APRNs is dependent upon individual hospital policy. APRNs must have graduated from an accredited graduate program and be nationally board certified to enter into practice in West Virginia.

#### Reimbursement

Family, pediatric, gerontologic, adult, women's health, and psychiatric NPs receive Medicaid reimbursement at 100% of the physician rate. State law requires insurance companies to reimburse nurses for their services, if such services are commonly reimbursed for other providers; however, rules and regulations have not been promulgated. NPs and CNMs are defined as a PCP: A person who may be chosen or designated in lieu of a primary care physician who will be responsible for coordinating the healthcare of the subscriber.

The only restriction is that the NP or CNM must have a written association with a physician listed by the managed-care panel; there is no requirement for employment or supervision by the physician. The Women's Access to Healthcare Bill provided for direct access, at least annually, to a woman's healthcare provider for a well-woman exam. Providers include APRNs, CNPs, CNMs, FNPs, WHNPs, adult NPs, GNPs, or PNPs.

#### Prescriptive authority

Qualified APRNs have Rx authority requiring a collaborative relationship with a licensed physician. Legislation passed in 2016 authorizes limited autonomous Rx authority, excluding Schedules I and II controlled substances, antineoplastics, radiopharmaceuticals, and general anesthetics, following 3 years of a duly-documented collaborative relationship with a physician.

The law provides for the development of the Joint Advisory Council on Limited Prescriptive Authority, comprised of MDs, DOs, APRNs, a pharmacist, a consumer, and a representative from a school of public health or an institution of higher education

who may advise the BON regarding collaborative agreements and evaluate applications for APRNs to prescribe without a collaborative agreement.

Rx authority includes Schedules III-V controlled substances with some restrictions. Drugs listed as Schedule III controlled substances are limited to a 30-day supply, and rules apply when prescribing for the treatment of a chronic condition (§30-7-15a (b)). Rules and regulations specify that APRNs must meet specified pharmacology education requirements. When required, the written collaborative agreement must include guidelines or protocols describing the individual and shared responsibility between the APRN and physician with periodic joint evaluation of the practice and review/ updating of the written guidelines or protocols.

No supervision requirement exists; APRNs are not required to be employed by a collaborating physician. The APRN works from an exclusionary formulary and Schedules I and II controlled substances, antineoplastics, radiopharmaceuticals, and general anesthetics are prohibited. Prior to the initial provision of a pain-relieving controlled substance, the APRN must access the West Virginia Controlled Substances Monitoring Program repository and database to determine if the patient has obtained any controlled substance from another prescriber within the 12-month period preceding the current visit. This must be documented and must be accessed by the current prescriber at least annually when treating a chronic pain condition. A DEA number is issued directly to APRNs by the DEA, and APRNs are authorized to sign for and provide drug samples.

### Wisconsin

www.wisconsinnurses.org www.dsps.wi.gov/Licenses-Permits/ Credentialing/Health-Professions www.campaignforaction.org/state/wisconsin

#### Legal authority

The Wisconsin BON regulates the practice of APRNs defined as APNPs and includes CNP, CNS, CNM, and CRNA roles. SOP is not defined in statute for NPs, CNSs, or CRNAs with the exception of reference to Rx authority (Wisconsin Rule §N 8.10); however, SOP is defined in statute and rules for CNMs (Wisconsin Stat. §441.15(1) (b) and Wisconsin Administrative Rule § N4.06). APNPs must practice in a collaborative relationship with a physician. There are no statutory requirements for hospitals to grant staff privileges, and few have done so. Regulations require all patients to be "under the care of a physician, dentist, or podiatrist." An APNP must have a master's

degree in nursing or related field, national board certification, malpractice insurance (\$1 million)\$3 million), and 45 clinical pharmacology hours to enter into practice in Wisconsin.

#### Reimbursement

Specified, reimbursable billing codes have Medicaid reimbursement of 100% as submitted by all master's degree-prepared NPs or NPs who are certified. Reimbursement is up to the maximum allowed for physicians billing for the same service. Qualified NPs are paid directly regardless of their employment site or arrangement. There are Medicaid bonuses for NPs working in certain areas or for certain pediatric visits. CHAMPUS reimburses NPs, and home health RNs bill under their own provider number. Third-party reimbursement has not been addressed legislatively. Some managed-care panels are open to NPs, but few allow NPs to be the PCP of record.

#### Prescriptive authority

Eligible APNPs may prescribe legend drugs and Schedules II-V controlled substances as a delegated medical act under the NPA.

Wisconsin Administrative Rule \$N 8.06 describes limitations on Rx authority for Schedule II controlled substances. APNPs may dispense complementary pharmaceutical samples; they may also dispense drugs to a patient if the treatment facility is located at least 30 miles from the nearest pharmacy.

# Wyoming

https://nursing-online.state.wy.us www.wyonurse.org

www.campaignforaction.org/state/wyoming

#### Legal authority

The Wyoming BON grants APRNs the authority to practice via licensure and regulates their practice. APRNs include CNP, CNS, CNM, and CRNA roles. APRNs are not required to have a collaborative or supervisory relationship with a physician. The SOP of an APRN is defined in statute, within the NPA, and includes Rx authority and management of patients commensurate with national organizations and accrediting agencies.

APRNs are statutorily defined as PCPs and may be permitted to admit patients to a

hospital and hold hospital privileges, depending on individual hospital policies. A doctorate or master's degree in nursing in a specific APRN role and national board certification in that role are required to enter into practice as an APRN in Wyoming.

#### Reimbursement

APRNs are authorized to receive Medicaid payments at 100% of the physician rate. All PCPs may receive third-party payment; however, policies differ among third-party payers. The BON has no say in reimbursement policies.

#### Prescriptive authority

BON-approved APRNs may independently prescribe legend and Schedule II-V controlled substances. APRNs are considered independent providers and register for their own DEA numbers. APRNs who have Rx authority are legally authorized to request, receive, and dispense pharmaceutical samples. This is not addressed by the BON but possibly the Pharmacy Board, and prescriptions are labeled with the APRN name.