RealPeopleGroup; blackdovfx; Andrii Sedykh; EyeEm Mobile GmbH; Fahroni; and STILLFX; all via iStock.

Transformative change through APRN practice authority progress

By Susanne J. Phillips, DNP, APRN, FNP-BC, FAANP, FAAN

ABSTRACT

The 38th Annual APRN Legislative Update provides a comprehensive state-by-state analysis of the legislative and regulatory landscape shaping the advanced practice nursing profession across the United States. Drawing on survey data collected from relevant authorities in all 50 states and Washington, D.C., the report highlights significant progress in 2025 toward full practice authority and prescriptive authority expansion for advanced practice registered nurses (APRNs). It also provides an overview of statutory and regulatory changes enacted or passed in 2025 that affect APRN practice nationwide. Key themes among these changes include steps toward administrative modernization, pathways to independent prescribing, and incremental gains in reimbursement parity. Persistent challenges remain, particularly in required transition to practice periods and equitable payment models. This year's edition of the Legislative Update underscores accelerating momentum toward dismantling APRN practice barriers and increasing APRN utilization to improve care access, quality, and cost-effectiveness.

Keywords: advanced practice nursing, annual report, legislative update, practice authority, prescriptive authority

Welcome back to the Annual APRN Legislative Update. Each year, *The Nurse Practitioner* provides readers with a state-by-state overview of legislative and regulatory changes to advanced practice nursing throughout the United States. Although individual state associations and some national organizations issue timely updates throughout the year on relevant improvements to advanced practice nursing, *The Nurse Practitioner* journal's annual special report consolidates these developments into a single, authoritative resource. For the 38th edition, we once again report significant improvement to advanced practice registered nurse (APRN) scope of practice, prescriptive authority, and reimbursement policy nationwide.

Each year, APRNs and their stakeholders successfully improve the regulatory environment in which they practice by achieving or moving closer to full practice authority (FPA), removing mandated supervisory or collaborative requirements, improving access to APRN care to enhance healthcare quality and safety, and achieving reimbursement parity for APRN services.[1] The annual survey results offer valuable insights to multiple audiences and stakeholders:

- **APRNs** gain a deeper understanding of their practice authority both within and beyond their state of licensure.
- **Educators** receive information that helps them to prepare APRN students and other health professions students for their important roles in delivering high-quality, safe, and effective patient care.
- **Professional organizations and advocates** can use the report to enhance their advocacy strategies and resources.
- **Healthcare organizations and other employers** deepen their knowledge of APRN roles and scopes and learn how these professionals can be utilized across various settings to the fullest extent of their authority.
- **Other healthcare professionals** learn more about how APRN practice complements interdisciplinary care and improves patient access and outcomes.
- **Policymakers** gain perspective on APRNs' contributions to healthcare—including the access and value they provide to constituents—as well as the remaining barriers that exist to access to crucial APRN care.

Finally, of note, although the Annual APRN Legislative Update largely focuses on the CNP role, information on other APRN roles—including the clinical nurse specialist (CNS), the certified nurse midwife (CNM), and the certified registered nurse anesthetist (CRNA)—is also highlighted where applicable. Because each state defines the title "APRN" and its roles independently in statute, variations exist as described in the state summaries.

METHODS

A mixed methods survey was utilized with yes/no and fill-in-the-blank questions. Data were collected from executive representatives of state BONs and state APRN or nursing professional organizations between September and November 2025.

The survey was created in Google Forms and was sent to respondents via a hyperlink in an email to simplify communication and improve response time. Responses were collected in real time and follow-up procedures included email reminders sent biweekly, then weekly, until the deadline.

Survey measures included changes in statutory or regulatory language pertaining to practice authority, prescriptive authority, transition to practice (TTP), and reimbursement. Qualitative questions examined barriers to TTP implementation and status of post-licensure TTP policy.

Descriptive statistics were used to analyze survey responses. Yes/no questions were calculated as frequencies and percentages for each state. Qualitative responses were reviewed and categorized by theme to identify common regulatory requirements and variations across states with legislative or regulatory changes. Data were organized using Microsoft Excel and presented in tables to illustrate comparisons.

To ensure data accuracy and validity, survey responses were cross-referenced with publicly available state statutes and regulations from state BONs and state legislature websites. In cases where responses were incomplete or unclear, follow-up contact was made with the responding organization for attempt at clarification.

RESULTS & DISCUSSION

Of the surveyed 50 US states and the District of Columbia (N=51), 41 (80.4%) BONs and 45 (88.2%) APRN or nursing organizations responded. Among these responses, all 51 (100.0%) unique states/jurisdictions were represented. In 2025, 23 states (45.1% of respondents) enacted legislation and/or regulatory changes pertaining to APRN practice (*Table 1*).

This year's legislative changes reflect the evolving landscape of APRN practice authority, including progress toward FPA and expansion of prescriptive authority (including for controlled substances [CSs]) in certain states.

Additionally, the current edition of the journal's Annual APRN Legislative Update provides the approximate total number of APRNs licensed/certified in each US state and Washington, D.C. (*Table 2*).

Highlights from state legislation

Wisconsin passed a bipartisan bill (AB 257; 2025 Wisconsin Act 17) granting CNPs, CNSs, CNMs, and CRNAs eligibility for independent practice after completing 3,840 hours of professional nursing practice in a clinical setting over at least 24 months and 3,840 hours of practice as an APRN while collaborating with a physician or dentist over at least 24 months. This new law takes effect September 2026. In addition, the statute eliminates the title of "certified advanced practice nurse prescriber," instead defining CNPs, CNSs, CNMs, and CRNAs as "APRNs." Similarly, ***New Mexico*** passed legislation authorizing independent practice for CRNAs, and ***California*** clarified scope of practice for CRNAs in the

TABLE 1. State legislative and regulatory changes

Arizona	Arizona Revised Statutes (ARS) section 32-1635.02 was added related to provisional licensure or certification qualifications for APRNs, RNs, and LPNs
Arkansas	Act 959 (delegation authority), Act 431 (DME signature authority)
California	AB 836 (Midwifery Workforce Training Act), AB 876 (CRNA scope definition), AB 533 (Death Certificates)
Colorado	HB25-1082 (Death Certificates); SB25-152 (health identification requirements)
Delaware	HB 140 (Death with Dignity), HB 148 (Board authority)
Georgia	HB 1046 (death certificates, MD/APRN/PA ratios), HB 557 (emergency medications, disability parking permits)
Illinois	Public Act 104-0244 (CNM out-of-hospital birth services)
Kansas	Substitute SB No. 67 (CRNA prescriptive authority)
Nebraska	LB 281 (eliminated separate APRN Board)
Nevada	AB 319 (APRN supervision of medical assistants), SB 170 (firefighter physicals)
New Hampshire	SB 556 (reimbursement non-discrimination)
New Mexico	HB 178 (formulary requirement removal for CNPs and CNSs), CRNA independent practice
New York	Consolidated Laws of New York, Mental Hygiene Chapter 27, Title B, Section 9.27 (PMHNP authorization to sign involuntary admission orders)
North Carolina	SL 2025-2 (Hurricane Helene flexibility for NPs)
Ohio	SB 196 (global signature authority), HB 96 (CRNA reimbursement parity)
Oklahoma	HB 2298 (pathway to independent prescriptive authority)
Rhode Island	P.L 2025, Ch. 309 (CNPs authorized to be Medical Director of Medical Spas)
Texas	HB 541 (direct primary care models)
Virginia	SB1352 (permits CNMs and licensed certified midwives to enter into practice agreements with CNMs or licensed certified midwives who are authorized to practice independently)
Washington, D.C.	HORA 2024 (independent practice authority expansion)
West Virginia	SB 810 (CRNA cooperation model)
Wisconsin	2025 Wisconsin Act 17 (APRN independent practice authority following 3,840 TTP hours under the supervision of a physician or dentist)

state with the passage of AB 876, amending California Business and Professions Code § 2826 to define and authorize anesthesia services provided by CRNAs. Finally, ***Rhode Island*** has authorized CNPs to assume the role of "Medical Director" in the Medical Spas Safety Act (R.I. Gen Laws § 23-105-1 (7).

Prescriptive authority expansion

Victories in prescriptive authority expansion require breaking down barriers. In ***Kansas***, CRNAs gained full prescriptive authority, authorizing them to prescribe durable medical equipment (DME) and prescribe, procure, and administer any drug, including Schedules II-V CSs consistent with education and qualifications (K.S.A. 65-1158). This new authority aligns more closely with CNP, CNS, and CNM full prescriptive authority, improving access to needed pain control following surgical and other procedures. APRNs in ***Georgia*** report the passage of HB 557, authorizing APRNs and physician associates (PAs) to prescribe an emergency 5-day supply of hydrocodone or oxycodone products for patients aged 18 years and older.

In ***Oklahoma***, a pathway to independent prescriptive authority (OK H.B. No. 2298) was established. CNPs, CNMs, and CNSs in the state can now apply to prescribe Schedules III-V CSs independently after completing 6,240 hours (3 years) of prescribing under physician supervision. Effective November 1, 2025, the new law includes a grandfather clause whereby APRNs who have already earned the required experience can apply for independent prescribing authority. In ***Arkansas***, APRNs can now authorize DME, including diabetic shoes and shoe inserts, with amendment of Arkansas Code § 17-80-120(a)(2)(H). Finally, ***New Mexico*** removed the mandatory prescription drug formulary submission requirement (Chapter 101 [NM H.B. 178]) for CNPs and CNSs, who are now authorized to prescribe all medications within their scope of practice, significantly reducing administrative burden.

TTP requirement changes

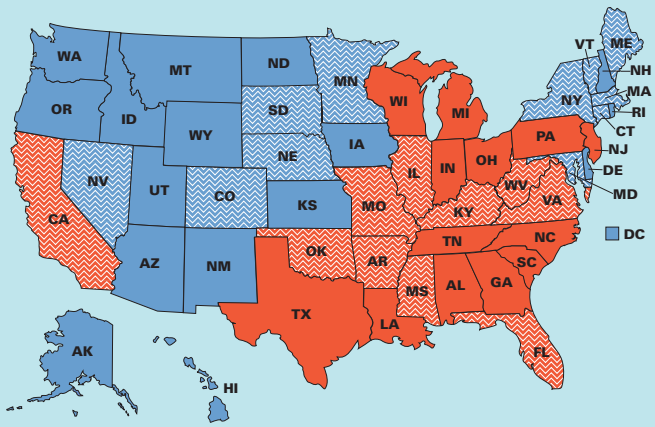
Regulatory variability persists nationwide (*Figure 1*), and several states (n=9) reported significant barriers to TTP requirement implementation. The most frequently cited hurdles included limited availability of qualified mentors or supervisors, financial constraints, and timing challenges. Specifically, mentorship barriers reported by states included lack of physician availability in rural areas, APRN mentor requirements and qualifications, and geographic mismatch between APRNs and supervisors. Identified financial barriers

TABLE 2. Total number of active clear licensed/certified APRNs in 2025

State	Total APRNs	CNPs	CNSs	CNMs	CRNAs
Alabama	12,326	10,189	50	57	2,030
Alaska	2,775	2,383	25	114	253
Arizona	20,090	18,042	119	364	1,565
Arkansas	6,071	4,814	128	63	1,066
California	52,593	44,751	3,007	1,474	3,361
Colorado#	11,306	9,345	475	526	970
Connecticut¥	9,095	*	*	262!	*
Delaware	5,812	5,170	67	85	490
Florida+	47,254	*	*	*	*
Georgia¥	20,838	17,943	159	675	2,061
Hawaii#	1,545	1,210	70	40	85
Idaho	6,340	5,317	56	113	854
Illinois¥#	20,194	16,301	819	473	2,599
Indiana	11,595	*	*	*	*
Iowa	10,405	9,232	63	182	928
Kansas	10,881	9,026	318	136	1,401
Kentucky#	15,889	13,661	120	180	1,920
Louisiana	10,445	8,509	115	100	1,721
Maine	5,062	4,274	47	118	623
Maryland	13,396	11,926	143	348	979
Massachusetts	20,616	17,938	519	570	1,589
Michigan¥+	15,862	14,972	325	565	3,147!
Minnesota	14,182	10,826	433	498	2,425
Mississippi	9,131	8,019	!	55	1,057
Missouri	16,586	13,846	230	229	2,281
Montana	4,475	3,982	33	112	348
Nebraska	5,865	4,910	67	98	790
Nevada	7,844	7,693	19	132	336!
New Hampshire	¥	¥	¥	¥	¥
New Jersey	16,000	*	*	!	*
New Mexico	8,292	7,441	91	!	760
New York	47,085~	47,085	^	!	!
North Carolina	21,337	16,287	275	559	4,216
North Dakota	3,039	2,470	37	41	491
Ohio#	31,532	25,276	1,703	636	3,797
Oklahoma	8,189	6,748	301	125	1,015
Oregon	11,632	9,927	122	479	1,104
Pennsylvania	~	22,428	289	-	^
Rhode Island%	^	3,342	114	!	233
South Carolina¥	11,656	9,332	83	144	2,097
South Dakota	3,535	2,863	42	69	561
Tennessee	22,186	18,530	116	359	3,181
Texas	54,227	46,282	842	702	6,401
Utah	7,671	6,426	*	265	980
Vermont	2,645	2,389	17@	104	135
Virginia	23,511	19,859	369	549	2,734
Washington#	18,456	16,245	113	676	1,420
Washington, D.C.	5,244	4,862	44	165	173
West Virginia#	6,313	5,207	20	81	1,031
Wisconsin	12,286	^	^	210	^
Wyoming	2,770	2,465	23	43	239

Note: The numbers reported in this table were shared with *The Nurse Practitioner* by state BONs and/or state RN or APRN associations between September and November 2025. In some instances, numbers were retrieved from BON websites or Centers for Nursing.
#Individual APRN category (CNP, CNS, CNM, CRNA) counts may not sum to total APRN counts. Numbers reported in this table are based on information collected directly from the state BON, state RN or APRN association, or BON website and are unchanged from the collected survey or BON website.
¥BON did not provide updated information to *The Nurse Practitioner*, and numbers were not available on BON website. If numbers are included in this table alongside this symbol, they reflect the most recently available data, as reported in the journal's past Annual APRN Legislative Updates.
*Number not tracked or provided individually; category count is included in total APRN counts for the state in question.
!Not recognized as a role within the APRN or equivalent category by the BON and not included in state's "Total APRNs" count.
+The latest data available reflect 2024 licensing.
^BON does not track the number of APRNs in this category or in total.
~"APRN" term not defined in statute or regulation.
-State does not define APRNs and BON does not regulate role; number not available.
%State tracks active licenses, not licensees.
@Only psychiatric CNSs recognized as APRNs.

FIGURE 1. Map depicting practice and prescriptive authority for CNPs in the US in 2025



Full practice* without TTP

Full practice* with TTP

Reduced practice* or restricted practice* with TTP

Reduced practice* or restricted practice* without TTP

Notes follow on individual state post-licensure practice periods required, per state law, prior to granting of the fullest extent of CNP practice authority allowable as defined in statute. APRN roles eligible for practice or prescriptive authority following the post-licensure practice period vary by state. State law may require that the APRN practice under supervision or mentorship of a qualified collaborating provider for the duration of the practice period. See individual state summaries for full details.

AR: 6,240-hour post-licensure practice period

CA: 3-year or 4,600-hour post-licensure practice period

CO: 750-hour post-licensure practice period

CT: 3-year and 2,000-hour post-licensure practice period

FL: 3,000-hour post-licensure practice period (for primary care practice as defined in statute) within the past 5 years; outside of primary care, NPs have restricted practice with no TTP

IL: 4,000-hour post-licensure practice period and 250 hours of CE or training

KY: 4 years of prescribing experience under collaborative agreements for nonscheduled legend drugs and CSs, respectively

MA: 2-year post-licensure practice period

MD: 18-month post-licensure practice period

ME: 24-month post-licensure practice period

MN: 2,080-hour post-licensure practice period

MO: 1,000-hour post-licensure practice period for CS prescriptive authority

MS: 1,000- to 2,000-hour post-licensure practice period

NE: 2,000-hour post-licensure practice period

NV: 2-year or 2,000-hour post-licensure practice period

NY: 3,600-hour post-licensure practice period

OK: 6,240 clinical hours of prescriptive authority under a supervising physician to apply for independent prescriptive authority (effective November 1, 2025); includes CS III-V

SD: 1,040-hour post-licensure practice period

VA: 3-year (5,400-hour) post-licensure practice period

VT: 2-year and 2,400-hour post-licensure practice period for primary credential; 1-year and 1,600-hour post-licensure period for secondary credential

WV: 3-year post-licensure practice period

*As defined by the AANP: https://www.aanp.org/advocacy/state/state-practice-environment

included high supervisory fees charged to APRNs by collaborating physicians, APRN income loss during supervised practice, and practice setting limitations. Finally, timing challenges encompassed delay of practice after graduation, difficulty in maintaining clinical competency during practice gaps, and license renewal complications.

Reimbursement parity

Reimbursement parity continues to challenge many states. Although several states reported 100% parity with physician rates for Medicaid and private payers, NPs in the majority of states receive partial reimbursement (75% to 85%) for equivalent services; individual state summaries elucidate the reimbursement landscape by location. Lower reimbursement rates continue to limit patient access and choice as well as to create economic strain on healthcare systems as a whole. Notably, ***New Hampshire*** enacted Chapter 0306, effective January 1, 2025, prohibiting health insurers from basing payment or reimbursement provisions solely on APRN licensure.

Signature authority and administrative modernization

States continue to expand APRN signature authority, signaling continued administrative modernization. ***California*** amended Health and Safety Code § 102795, 102800, and 102825 to allow CNPs to complete and sign death certificates. Effective March 2025, global signature authority was rolled out for CNPs, CNMs, and CNSs in ***Ohio*** (S.B. 196). These practical legal changes reduce bureaucratic delays and improve patient care continuity and administrative efficiency.

LIMITATIONS

Several limitations should be noted. First, the binary nature of yes/no questions may not capture the complexity of some nuanced regulatory provisions. Second, qualitative responses varied in detail and specificity, which may reflect differences in respondent knowledge or interpretation rather than actual regulatory differences. Third, self-reported survey data were subject to potential response bias, though efforts were made to verify responses against official state documents.

CONCLUSION

The 2025 data reveal accelerating momentum toward dismantling practice barriers. With about half of respondent states enacting changes in the past year, the regulatory landscape is evolving more rapidly than in previous decades. Among ongoing priorities, reimbursement parity is emerging as a critical battleground. As healthcare systems face workforce shortages and rural access crises, economic arguments for APRN utilization are becoming irrefutable. States achieving 100% reimbursement parity demonstrate that equitable payment is both feasible and necessary for sustainable healthcare delivery models.

In the future, emphasis is likely to be placed on interstate licensure and telehealth expansion, making state-by-state practice authority variations increasingly untenable and regulatory harmonization essential. Implementation gaps between statutory authority and practical reality remain the most significant challenge. Future advocacy must therefore focus not only on legislative wins but also on addressing financial barriers to collaboration, ensuring insurance companies comply with statutory requirements, and supporting APRNs through TTP periods.

The 2026 Legislative Update demonstrates that incremental progress compounds into transformative change. While nationwide FPA remains aspirational, the data reflect a clear trajectory. The question is no longer *whether* APRNs should practice to the full extent of their education and training, but *how quickly* remaining barriers can be dismantled to guarantee universal access to high-quality, affordable care.

NOTE

The historical context of APRN practice authority can be found in numerous texts, including journal articles and other media; however, the most up-to-date information on legislative changes can be found on state BON and APRN professional organization websites.[2] For ease of reference, these web addresses are included at the beginning of each state's summary in this report. State BON and Health Professions regulatory board websites provide easy access to statutes and regulations pertaining to APRNs. For those who enjoy a research challenge, the state legislature, and statutory and regulatory websites, provide search functions for recent or past bills and regulatory changes.

REFERENCES

1. American Association for Nurse Practitioners. (2025). *Issues at a Glance: Full Practice Authority*. https://www.aanp.org/advocacy/advocacy-resource/policy-briefs/issues-full-practice-brief
2. Tracey, M.F., O'Grady, E.T., & Phillips, S.J. (2022). Hamric & Hansons Advanced Practice Nursing: An Integrative Approach, 7th Ed. Elsevier. DOI: 978-0-323-77711-7

Susanne J. Phillips is a family NP and senior associate dean and clinical professor at the Sue & Bill Gross School of Nursing, University of California, Irvine in Irvine, Calif.

The author has disclosed no potential conflicts of interest, financial or otherwise.

Acknowledgements: The author would like to thank Dr. Jamie Newland for 20 years of encouragement and guidance in the development of the Legislative Update. The author would also like to acknowledge the state BON and APRN organization representatives for providing data for this Legislative Update. Finally, the author would like to acknowledge the Annual APRN Legislative Update staff, Jen Zimmerman and Kimberly Yoon, for their invaluable administrative assistance with editing, data collection, and organization.

DOI-10.1097/01.NPR.0000000000000400

Key

AANP American Association of Nurse Practitioners
APN Advanced Practice Nurse
APRN Advanced Practice Registered Nurse
ARNP Advanced Registered Nurse Practitioner
BC/BS Blue Cross/Blue Shield
BOM Board of Medicine
BOME Board of Medical Examiners
BON Board of Nursing
BOP Board of Pharmacy
CARES Act Coronavirus Aid, Relief, and Economic Security Act
CE Continuing Education
CHAMPUS Civilian Health and Medical Program of the Uniformed Services
CME Continuing Medical Education
CNM Certified Nurse Midwife
CNP Certified Nurse Practitioner
CNS Clinical Nurse Specialist
CPA Collaborative Practice Agreement
CRNA Certified Registered Nurse Anesthetist
CRNP Certified Registered Nurse Practitioner
CS Controlled Substance
DEA Drug Enforcement Administration
DME Durable Medical Equipment
DO Doctor of Osteopathic Medicine
FNP Family Nurse Practitioner
FPA Full Practice Authority
HMO Health Maintenance Organization
MAT Medication-Assisted Treatment
MCO Managed Care Organization
NCSBN National Council of State Boards of Nursing
NPA Nurse Practice Act
NPI National Provider Identifier
OTC Over the Counter
PCP Primary Care Provider
PCNS Psychiatric Clinical Nurse Specialist
PDMP Prescription Drug Monitoring Program
PMHNP Psychiatric-Mental Health Nurse Practitioner
PNP Pediatric Nurse Practitioner
RNP Registered Nurse Practitioner
R&R Rules and Regulations
SOP Scope of Practice
TTP Transition to Practice
WHNP Women's Health Nurse Practitioner

Alabama

www.abn.alabama.gov
www.npalliancealabama.org
https://alabamanurses.nursingnetwork.com/

PRACTICE AUTHORITY

The Alabama state BON has sole regulatory authority to establish qualifications of and certification requirements for APRNs; however, Alabama remains a collaborative practice state, and the BOME retains regulatory authority over physicians engaged in collaborative practice with CRNPs or CNMs. APRNs are defined as "APNs" in Alabama statute and include the CNP ("CRNP" in statute), CNS, CNM, and CRNA roles. CRNPs and CNMs practice within BON- and BOME-approved written CPA protocols; however, collaboration does not require direct, on-site supervision by the collaborating physician. Professional oversight and direction are required as outlined in Alabama BON Administrative Code Chapter 610-X-5-.09 and Chapter 610-X-5-.20 and include a requirement for on-site physician attendance (a minimum of 10% of the CNP/CNM's scheduled hours) when the CRNP or CNM has fewer than 2 years of collaborative practice experience.

Alabama meets the AANP's criteria for a reduced practice state. APRN SOP is defined in regulation, and APRNs practice in accordance with national standards and functions identified by the appropriate specialty-certifying agency, congruent with Alabama law.

CRNPs and CNMs must hold a master's or higher degree in advanced practice nursing and must hold and maintain national board certification, with a few exceptions, pursuant to Alabama BON Administrative Code Chapter 610-X-5-.03 and Chapter 610-X-5-.14. No TTP is required for APRNs in the state of Alabama.

CRNPs and CNMs may prescribe, administer, and provide therapeutic tests and drugs within a BON- and BOME-approved protocol and formulary. In collaborative practice with a physician, CRNPs and CNMs may prescribe Schedules III-V CSs and, under limited circumstances, Schedule II CSs, pursuant to rules of the Alabama BOME Administrative Code Chapter 540-X-18-.07. In addition to DEA registration, a Qualified Alabama Controlled Substances Registration Certificate is required for eligible CRNPs and CNMs to prescribe these drugs.

Under current regulation for Schedules III-V prescribing authority, CRNPs and CNMs are required to complete 12 CME contact hours in the prescribing of CSs, advanced pharmacology, and prescribing trends, and they must complete 4 additional contact hours every 2 years for Qualified Alabama Controlled Substances Registration Certificate renewal. All CRNPs and CNMs are required to access the Alabama PDMP.

REIMBURSEMENT

There are no legislative restrictions for APRNs 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 Alabama Medicaid program for services provided by the CRNP may not enroll. BC/BS will reimburse CRNPs and CNMs working in collaboration with a preferred physician provider at 70% of the physician rate.

Alaska

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

PRACTICE AUTHORITY

The Alaska BON regulates the APRN role, which statute defines as including the CNP, CNS, CNM, and CRNA functions. APRNs are further defined as RNs who, due to specialized education and experience, are certified to perform the acts of medical diagnosis and prescription as well as to dispense medical, therapeutic, or corrective measures under regulations adopted by the BON. Alaska meets the AANP's definition of FPA.

APRN SOP is defined under 12 Alaska Administrative Code (AAC) 44.430. 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. The state does not require a TTP period. APRNs are authorized to issue do-not-resuscitate (DNR) orders and death certificates.

Authorized APRNs have independent prescriptive authority, including for Schedules II-V CSs. APRNs are legally required to review the PDMP database prior to prescribing CSs and must complete 2 CE hours in pain management, opioid use, and addiction each 2-year license renewal cycle. APRNs are legally authorized to request, receive, and dispense pharmaceutical samples in Alaska. To renew prescriptive authority, APRNs must maintain national certification and complete the opioid CE requirement. Opioid prescribing limitations restrict the number of therapy days that can be prescribed by an APRN.

REIMBURSEMENT

All healthcare in Alaska is provided on a fee-for-service basis. FNPs, PNPs, PMHNPs, CNMs, and CRNAs 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.

Arizona

www.azbn.gov
https://aapnn.enpnetwork.com

PRACTICE AUTHORITY

The Arizona State Legislature grants APRNs authority, and the BON alone regulates their practice. In Arizona, APRNs include CNPs ("RNPs" in statute), CNSs, CNMs, and CRNAs. According to Arizona Revised Statutes (ARS) section 32-1601, RNPs and CNMs in the state are RNs who have an expanded SOP, which includes "recognizing the limits of [their] 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 CPA is required. Arizona meets the AANP's criteria for FPA.

RNP SOP standards are defined in Arizona Administrative Code R4-19-508, which indicates that RNPs are authorized to admit patients to healthcare facilities, manage the care of admitted patients, and discharge patients. However, Arizona Department of Health regulations require an attending physician for patients admitted to an acute care facility. Acute care facilities apply this citation as the basis for denying independent admitting and hospital privileges to RNPs.

RNPs, CNMs, and CNSs must have a graduate degree in nursing and hold national board certification in their focus area to begin practice. CRNAs must have a graduate degree associated with an accredited CRNA program and hold national certification to begin practice. CRNAs are responsible for their own practice; physicians and surgeons are not liable for any act of or omission by a CRNA who orders or administers anesthetics.

RNPs have full prescribing and dispensing authority, including of Schedules II-V CSs, on application and fulfillment of BON-established criteria. RNP prescribing and dispensing authority is linked to the RNP's area of population focus and certification. An RNP with prescribing and dispensing authority who wishes to prescribe a CS must apply to the DEA for a registration number and submit this number to the BON and the BOP. Drugs (other than Schedules II-IV CSs) prescribed by the RNP may be refilled for up to 1 year. The passage of ARS section 36-2606 requires RNPs who intend to hold or already hold a DEA registration number to also hold Arizona Controlled Substances Prescription Monitoring Program (CSPMP) registration issued by the BOP.

Prescribers must obtain a patient utilization report from the CSPMP's central database prior to prescribing an opioid analgesic or benzodiazepine CS in Schedule II, III, or IV, with certain exceptions. CRNAs are not authorized to prescribe or dispense medications for patients to use outside of the CRNA's practice setting. Since 2019, CNSs have had prescriptive authority, but it is limited to prescribing in healthcare facilities.

REIMBURSEMENT

RNPs and other APRNs may receive third-party reimbursement, enabled by statutes of the Arizona Department of Insurance and Financial Institutions as well as the Arizona Health Care Cost Containment System (Arizona's Medicaid agency). RNP reimbursement varies, depending on the health plan.

Arkansas

www.arsbn.org
https://anpassociation.enpnetwork.com

PRACTICE AUTHORITY

The Arkansas BON grants APRNs in the state authority to practice and regulates their practice. The term APRN is defined to include the CNP, CNM, CNS, and CRNA roles. CNPs and CNSs are authorized to apply for full independent practice authority with prescriptive authority from the Full Independent Practice Credentialing Committee, as defined in Arkansas Code § 17-87-314. CNPs and CNSs are required to complete 6,240 hours of practice with a physician under a board-required agreement prior to applying for full independent practice. CNMs have FPA as defined in Arkansas Code § 17-87-315. CRNAs practice in consultation with a physician. APRNs practice within scope and standards defined in Title 17, Chapter XXII, Part 123 of the Code of Arkansas Rules as well as standards established by the national certifying body from which the APRN holds their certification required for licensure. Arkansas meets the AANP's criteria for a reduced practice state.

APRNs are recognized as PCPs within the Arkansas Medicaid system. Hospital privileges for APRNs are determined on a hospital-to-hospital basis according to each hospital's credentialing committee. Initial APRN licensure is granted to applicants who have completed 2,000 hours of active practice as an RN, have completed graduate- or postgraduate-level APRN education, and hold active national board certification. APRNs must maintain active certification for APRN licensure renewal.

Arkansas Code § 17-87-310 authorizes the BON, upon the APRN's application, to issue the APRN a certificate of prescriptive authority if they either hold a certificate of full independent practice authority under § 17-87-314 or are working within a board-authorized agreement with a physician or podiatrist. Once granted, CNPs and CNSs may receive and prescribe drugs, medicines, or therapeutic devices in the CNP or CNS's area of practice, including Schedules II-V CSs, with certain limitations. CNMs have prescriptive authority, including for Schedules III-V CSs, without a CPA. Schedule II CSs may be prescribed by CNMs in collaboration with a physician. CRNAs are not required to have prescriptive authority to provide anesthesia care, including the administration of drugs or medication necessary for such care.

APRNs with prescriptive authority must review the PDMP prior to prescribing an opioid from Schedule II or III every time they prescribe the medication to a patient; they must review the PDMP in prescribing a benzodiazepine or Schedule II stimulant for the first time and every 6 months thereafter. APRNs who have fulfilled requirements for prescriptive authority may receive and dispense pharmaceutical samples and therapeutic devices in their area of practice, including Schedules III-V CSs and certain Schedule II CSs. Co-prescription of an opioid antagonist is required of all providers in Arkansas when an opioid or opioid/benzodiazepine is prescribed, except under certain circumstances. PDMP review exceptions are described in Code of Arkansas Rules Title 17, Chapter XXII, Part 123, subpart 6 (17 CAR §123-611).

REIMBURSEMENT

The NPA mandates direct Medicaid reimbursement to APRNs and RNPs. Act 569 of the Arkansas General Assembly, signed into law in 2021, authorizes APRN reimbursement at 100% of the physician rate. A statutory provision exists for third-party reimbursement for CRNAs.

California

www.rn.ca.gov
https://canpweb.org

PRACTICE AUTHORITY

The California BON regulates the practice of APRNs, defined in statute to include the CNP, CNS, CNM, and CRNA roles. In January 2020, legislation was passed granting NPs autonomous practice following completion of a 3-year or 4,600-hour TTP period. During the TTP period, NPs are supervised by an NP or physician and surgeon and practice pursuant to a "standardized procedure," which defines their SOP, supervision requirements, evaluation, authority to practice outside the RN SOP, etc. Following completion of the TTP period and with board certification, CNPs are authorized to apply for a 103 NP certificate, through which they can practice autonomously in certain group settings pursuant to their SOP as defined in Business and Professions Code (BPC) § 2837.103. For the CNP to practice autonomously outside of a defined healthcare setting described in BPC § 2837.103, the CNP must meet additional requirements for independent practice pursuant to BPC § 2837.104 and apply for a 104 NP certificate on or after January 1, 2026. The AANP considers NP practice in California to be restricted practice.

CNMs do not require physician supervision to practice within their scope of practice as defined in BPC § 2746.5. CNMs who desire to practice outside of the CNM SOP are authorized to do so utilizing a standardized procedure. The general scope of practice for CRNAs is governed by BPC § 2725, and anesthesia services are provided by a nurse anesthetist autonomously when ordered by a physician and surgeon. CRNAs practice pursuant to CRNA Scope of Practice and Standards of Practice defined by the American Association of Nurse Anesthesiologists. CNSs practice under the RN SOP. APRNs are not legally authorized to admit patients to a hospital; however, individual hospitals grant APRNs hospital privileges through the credentialing process. APRNs must hold a minimum of a master's degree in nursing or a health-related field to practice. CNPs with independent practice (103 or 104) must hold a master's degree or doctorate in nursing and national certification in one of the seven recognized NP specialties. CRNAs are required to hold national certification to practice in the state of California.

During the TTP period, CNPs furnish drugs and devices, including Schedules II-V CSs, under supervision of a 103 NP, 104 NP, or physician. CNPs certified by the BON as independent practice providers (103 NPs and 104 NPs) are authorized to independently prescribe drugs and devices, including Schedules II-V CSs. CNMs are authorized to furnish drugs and devices without a standardized procedure if the drugs and devices are within their scope of services. CNMs may furnish or order drugs or devices, including Schedules II-V CSs, outside of the scope of services defined in statute when furnished in accordance with a standardized procedure. The act of furnishing is legally the same as prescribing.

All prescribers are mandated to consult the Controlled Substance Utilization Review and Evaluation System (CURES) each time a patient is prescribed, ordered, administered, or furnished a CS if the CS remains a part of the patient's treatment plan (with some exemptions). CNPs and CNMs may request, receive, and dispense pharmaceutical samples and dispense drugs, including CSs. CNSs and CRNAs do not have prescriptive authority in 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. California law does not preclude third-party reimbursement of services, and policies vary from payer to payer; however, third-party payers are legally required to reimburse CNMs and Board of Registered Nursing-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.

Colorado

https://dpo.colorado.gov/Nursing
https://www.coloradonurses.org

PRACTICE AUTHORITY

The Colorado BON grants advanced practice authority to RNs who meet the criteria set forth in the Nurses and Nurse Aides Practice Act (Colorado Revised Statutes § 12-255-111) and the Nursing Rules and Regulations (3 Code of Colorado Regulations [CCR] 716-1, Rule 1.14) for inclusion on the Advanced Practice Registry (APR). The Board regulates the practice of APRNs and affords title protection. In Colorado, APRNs include the CNP ("NP" in statute), CNS, CNM, and CRNA roles. Professional liability insurance is required for all APRNs engaged in independent practice.

The scope of advanced practice registered nursing may include, but is not limited to, performing acts of advanced assessment, diagnosis, and treatment, including prescribing, ordering, selecting, administering, and dispensing diagnostic and therapeutic measures, all within the APRN's role and population focus. The scope does not include prescribing medication; however, the Board grants separate prescriptive authority. APRNs are considered independent practitioners. NP practice in Colorado meets the AANP's criteria for FPA.

National certification in a role and, if applicable, population focus is required of all APRN applicants. APRNs are recognized as primary care providers in Colorado. APRNs are authorized to sign death certificates provided by the Department of Health and Environment.

The APRN may be granted prescriptive authority by the Board within the APRN's role and population focus. If granted, prescriptive authority includes prescription of Schedules II-V CSs. APRNs must have 3 years of clinical work experience as an RN or an APRN to be eligible to apply for provisional

prescriptive authority. An APRN with provisional prescriptive authority must complete a 750-hour prescribing mentorship with a physician or an APRN with full prescriptive authority to be eligible to apply for full prescriptive authority. APRNs with either provisional or full prescriptive authority must have a valid DEA registration to prescribe CSs. APRNs who have active prescriptive authority in another state and more than 750 hours of prescribing experience in that state are not required to complete the mentorship period.

Pursuant to the Substance Use Disorders Prevention Measures Act, the BON has adopted rules on substance use disorder training for prescribers. Training must consist of at least 2 credit hours per licensing cycle related to best practices for opioid prescribing, recognition of substance use disorders, referral for and treatment of substance use disorders, and use of the PDMP. APRNs and other prescribers are not permitted to accept direct or indirect benefits for prescribing specific medications.

REIMBURSEMENT

Medicaid reimburses APRN services; however, some managed care Medicaid companies restrict independent APRNs from joining networks. Third-party reimbursement is available to APRNs, but third-party payers are not mandated to credential, empanel, or reimburse APRNs. NPs with prescriptive authority are authorized to receive Level I Accreditation for the purpose of receiving 100% reimbursement under the medical fee schedule within the Workers' Compensation Act of Colorado. CNMs are a recognized provider type within Colorado's Medicaid program, Health First Colorado. APRNs are also recognized as healthcare providers throughout Colorado's Standardized Health Benefit Plan, including reimbursement for services.

Connecticut

https://portal.ct.gov/DPH/Public-Health-Hearing-Office/Board-of-Examiners-for-Nursing/Board-of-Examiners-for-Nursing/
www.ctaprns.org

PRACTICE AUTHORITY

The Connecticut Board of Examiners for Nursing regulates APRNs, defining the role in statute as including the CNP ("NP" in statute), CNS, and CRNA roles. APRN SOP, independent practice, and collaborative practice are defined in statute. APRNs enjoy expanded signature authority in Connecticut and are authorized to certify patients for medical marijuana use. CNM authority is regulated by the Department of Public Health, and CNM SOP is recognized under a separate statute.

A graduate degree in nursing or other related field and national board certification are required for advanced nursing practice in the state, and APRNs are statutorily recognized as PCPs, with authorization to hold hospital privileges, including admission of patients. Following passage of the federal CARES Act, Connecticut's governor signed Public Act No. 21-133, authorizing APRNs to issue orders for home healthcare services, hospice agency services, and home health aide agency services. A TTP requirement exists in Connecticut whereby APRNs are authorized to practice without a collaborative agreement following no fewer than 3 years and 2,000 hours of practice in collaboration with a Connecticut-licensed physician. In 2023, Connecticut passed a law authorizing independent practice reciprocity for NPs who previously practiced in another state, as long as the aforementioned Connecticut collaborative practice requirements were met in that state. NP practice in Connecticut constitutes FPA as defined by the AANP.

APRNs are authorized to prescribe, dispense, and administer medications, including CSs, pursuant to a collaborative agreement. APRNs may independently prescribe, dispense, and administer medications, including Schedules II-V CSs, following a TTP period of no fewer than 3 years and 2,000 hours. APRNs and CNMs are legally authorized to request, receive, and dispense pharmaceutical samples.

Opioid prescribing limitations require that initial prescriptions for outpatient use for adults be restricted to a 7-day supply and that any opioid prescribing for minors be limited to a 5-day supply. Opioid prescriptions may not need to be limited when prescribing for chronic pain, cancer pain, palliative care, substance use disorder, and patients who require MAT, and exceptions to the prescribing limitations for acute medical conditions may be made based on provider judgment.

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 constitute services that are reimbursable 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.

Delaware

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

PRACTICE AUTHORITY

The Delaware BON regulates the practice of APRNs, which include the CNP, CNS, CNM, and CRNA roles in the state. The BON has sole regulatory authority over APRNs and grants FPA upon issuance of an APRN license. APRN SOP is defined in statute, wherein APRNs are recognized as independent licensed practitioners. To be licensed in Delaware, APRNs must graduate from or complete a graduate-level APRN program accredited by a national accrediting body and hold current certification by a national certifying body in the appropriate role and population focus area. NP practice in Delaware meets the AANP's criteria for FPA.

APRNs have authority to serve as PCPs by an insurer or healthcare services corporation. APRNs licensed by the BON may prescribe, order, procure, administer, store, dispense, and furnish OTC and legend medications, including Schedules II-V CSs, pursuant to applicable state and federal laws and within the APRN's role and population focus. Additionally, APRNs may order and prescribe nonpharmacologic interventions, including medical devices and DME; nutrition, blood, and blood products; and diagnostic and supportive services, including home healthcare, hospice, physical therapy, and occupational therapy. APRNs may receive, sign for, record, and distribute sample medications to patients in accordance with state and federal DEA laws, regulations, and guidelines.

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 their SOP. APRNs may be listed on provider panels, and some payers recognize APRNs 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.

Florida

www.floridasnursing.gov
https://fnpn.enpnetwork.com
www.flanp.org

PRACTICE AUTHORITY

The Florida BON regulates APRN practice defined in statute. In Florida, APRNs include CNPs, CNSs, CNMs, and CRNAs. APRNs practice within established protocols under the supervision of a physician. APRNs in primary care practice (family medicine, general pediatrics, and general internal medicine), however, may register for autonomous practice following a TTP period of 3,000 clinical practice hours, completed within the last 5 years immediately preceding the registration request. The term "primary care practice" has been defined by the BON in Florida Administrative Code 64B9-4.001. CNMs may engage in autonomous practice pursuant to Florida Statutes, Title XXXII, Chapter 464.012. SOP for autonomous APRN practice is defined in Chapter 464.0123, 464.012(3), and 464.012(4)(c) of the same, and it includes prescriptive authority, with the ability to prescribe CSs.

Outside of primary care, APRNs continue to practice—including performance of medical acts of diagnosis, treatment, and operation—pursuant to protocols requiring supervision by a physician (MD or DO) or dentist. Within the framework of established protocols, APRNs may order diagnostic tests, physical therapy, and occupational therapy. Supervision is defined as the ability to communicate or establish contact by telephone; the supervising practitioner's on-site presence is not required. Florida meets the AANP's criteria for a restricted practice state.

APRNs are authorized to admit patients to a hospital and hold hospital privileges dependent on privileges granted by the institution and the supervising physician. APRN applicants must have a master's degree to qualify for initial licensure and are required to hold national board certification to practice. CNSs must either hold a national certification in a CNS specialty or proof of completed clinical experience in a CNS specialty for which there is no national certification.

APRNs without autonomous practice authority are authorized by supervisory protocol to prescribe, dispense, administer, or order any drug, including Schedules II-V CSs as authorized in a BON-adopted CS formulary, with certain exceptions. Additionally, psychiatric-mental health board-certified APRNs may prescribe psychotropic CSs. APRNs are also authorized to request, receive, or dispense pharmaceutical samples.

Opioid prescribing restrictions limit opioid prescribing for acute pain to 3 days; exceptions in dispensing restrictions allow for MAT. A 7-day supply is permitted if medically necessary based on professional judgment.

REIMBURSEMENT

APRNs receive Medicaid, Medicare, CHAMPUS, and third-party reimbursement. Medicaid reimburses APRNs at 100% of the physician rate only if the on-site physician countersigns within 24 hours; otherwise, Medicaid reimburses APRNs at 85% of the physician rate if the physician is not on site and does not countersign. Managed care companies are prohibited from discriminating against APRNs for reimbursement based on licensure. Private insurers must reimburse CNM services if the policy includes pregnancy care.

Georgia

https://sos.ga.gov/georgia-board-nursing
https://uaprn.enpnetwork.com

PRACTICE AUTHORITY

APRNs, including the CNP (in statute), CNM, CRNA, CNS, and CNS in psychiatric/mental health roles, are licensed and regulated by the BON and defined in Official Code of Georgia Annotated (OCGA) § 43-26-3. APRN practice authority is granted in R&R of the State of Georgia (GA R&R) 410-11-.01 in accordance with defined scope and standards of practice including advanced nursing functions. Pursuant to OCGA § 43-34-25, an APRN may enter into a nurse protocol agreement with a physician where they may be delegated certain medical acts, including prescriptive authority. A master's degree or higher in nursing or a related field and national board certification are required for all APRNs at entry into practice. NP practice in Georgia is considered restricted by the AANP.

Prescriptive authority is jointly regulated by the BON and the BOM. Physicians may delegate prescriptive authority to RNs and APRNs through a nurse protocol agreement approved by the BOM pursuant to § 43-34-23 and § 43-34-25. The nurse protocol agreement may contain

authorization to order CSs selected from a formulary of such drugs established by the BOM (including the Schedule II CSs hydrocodone, oxycodone, or compounds thereof limited to an emergency 5-day supply for patients age 18 and older and Schedule III-V CSs) and the authority to order dangerous drugs, medical treatments, and diagnostic studies. APRNS can be delegated to sign death certificates, appoint guardianship, and sign handicap placards.

REIMBURSEMENT

No statutes mandate third-party reimbursement for APRNs. FNPs, PNPs, WHNPs, CNMs, and CRNAs are eligible for Medicaid reimbursement from the Georgia 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 to do so by law. A managed care system, health plan, hospital, insurance company, or other similar entity shall not require a physician or APRN to be a party to a nurse protocol agreement as a condition for participation in or reimbursement from such entity (OCGA § 43-34-25).

Hawaii

www.hawaii.gov/dcca/pvl/boards/nursing
https://hapnhawaii.enpnetwork.com/

PRACTICE AUTHORITY

In Hawaii, the BON licenses and regulates APRNs consistent with the APRN Consensus Model. APRNs include CNP ("NP" in regulation), CNS, CNM, and CRNA roles. All APRNs have independent SOP, including authorization to certify patients for medical marijuana use when the APRN holds prescriptive authority and is registered with the State of Hawaii Department of Public Safety, Narcotics Enforcement Division. APRN SOP is defined in statute and regulation and conforms to the NCSBN Model Act. Hospitals licensed in Hawaii recognize APRNs, allow them to function with full SOP, and authorize APRNs to act as PCPs in their institutions. 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. The AANP defines Hawaii's state practice environment as full practice.

APRNs in Hawaii apply separately for prescriptive authority and once granted, may prescribe medications and medical devices including Schedules II-V CSs independently within their specialty. APRNs prescribe pursuant to an exclusionary formulary established by the BON (HAR §16-89-122) precluding their prescription of investigational drugs (except as part of an institutional review board [IRB]-approved clinical trial); stimulants and hormones for treatment of obesity; human growth hormones, anabolic steroids, or hormones for performance enhancement or antiaging; and methadone for detoxification or maintenance. APRNs with prescriptive authority are legally authorized to request, receive, and dispense manufacturers' prepackaged pharmaceutical samples, excluding CS samples. Opioid prescribing restrictions affecting all practitioners were reenacted in 2023 (HRS § 329-38).

REIMBURSEMENT

Current law provides direct reimbursement to APRNs and authorizes all insurers to recognize APRNs legally as PCPs. The reimbursement rate range is 85% to 100% of the physician payment. NPs and CNSs are also reimbursed through CHAMPUS. Medicaid reimburses various types of APRNs, including PCNSs and additional NP specialties. Medicaid reimburses 100% of the physician payment. Med-QUEST, a Medicaid waiver program, defines PNPs, FNPs, and CNMs as PCPs in Hawaii.

Idaho

https://dopl.idaho.gov/bon/
https://npidaho.enpnetwork.com/

PRACTICE AUTHORITY

The Idaho BON regulates the practice, licensure, and education of APRNs. The APRN role is defined in IDAPA 24.34.01 – Rules of the Idaho Board of Nursing and includes the CNP, CNS, CNM, and CRNA roles. APRN SOP is defined in statute and regulation (Idaho Code §54-1402(1) and IDAPA 24.34.01.200) and when functioning within the recognized scope of practice, assume primary responsibility for the care of their patients in diverse settings.

APRNs are legally authorized to admit patients to hospitals and hold hospital privileges, and facilities have granted privileges to them. State law requires current RN licensure in Idaho, successful completion of an approved graduate or postgraduate APRN program accredited by a national organization recognized by the Board, and current national certification by an organization recognized by the Board for the specified role. NP practice in Idaho meets AANP criteria for FPA.

Although APRNs are not statutorily recognized as PCPs, Idaho has "any willing provider" language in statute: Idaho Code §39-9203(6) states, "'Primary care provider' means a natural person licensed or otherwise legally authorized to provide health care services in the state of Idaho in the field of pediatrics, family medicine, internal medicine or dentistry, who provides such services either alone or in professional association with others in a form and within a scope permitted by such licensure or legal authorization for the provision of such services, and who enters into a direct primary care agreement."

Independent prescribing and dispensing authority are granted to qualified APRNs upon licensure. Authorized APRNs may prescribe and dispense legend drugs and Schedules II-V CSs appropriate to their defined SOP.

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

Illinois

https://idfpr.illinois.gov/profs/nursing.html
www.isapn.org

PRACTICE AUTHORITY

The Illinois Department of Financial and Professional Regulation (IDFPR) regulates APRN practice, including that of the CNP, CNS, CNM, and CRNA roles. APRNs, except for CRNAs, may apply for a FPA license as defined in 225 Illinois Compiled Statutes (ILCS) 65/65-43, following a TTP period of at least 4,000 clinical hours of experience in collaboration with a physician (following national certification in the APRN role), as well as completion of 250 hours of CE or training. APRN SOP is defined in 225 ILCS 65/65-30. All APRNs must practice in accordance with their national certification. Illinois is designated as a reduced practice state by the AANP.

Prior to receiving an FPA license, APRNs must have a written collaborative agreement with a physician, podiatric physician (CRNAs only), or dentist (CRNAs only), except those APRNs who provide services in a hospital, hospital affiliate, or ambulatory surgical treatment center (ASTC) and who have been granted clinical privileges by that facility.

A written collaborative agreement may permit a CNM to provide home birth services within the scope of their training and experience. A CNM may provide out-of-hospital birth services in a licensed birth center without a written collaborative agreement if granted by the clinical director of the birth center. Further, a CNM may provide out-of-hospital birth services in all practice settings consistent with national certification under a written collaborative agreement with an APRN with FPA in certain primary care health professional or maternity care shortage areas.

The APRN must hold a graduate degree, current RN licensure, and national certification as a CNP, CNS, CNM, or CRNA from the appropriate national certifying body as determined by rules of the IDFPR. CRNAs with active certification who completed their CRNA program prior to January 1, 1999 may be exempt; this exception expires on June 30, 2028.

In Illinois, APRNs with FPA are authorized to prescribe, select, order, administer, store, dispense, and accept samples of botanical and herbal remedies, OTC, legend drugs, and Schedules II-V CSs. An Illinois CS license is required in addition to DEA registration to prescribe CSs. All prescribers are required to enroll in the Illinois Prescription Monitoring Program and to check the program prior to initial prescription of Schedule II narcotics, such as opioids; they are also required to document the attempt in the patient's record. Prescribing Schedule II CSs is authorized only in a consultation relationship with a physician, which must be recorded using the Illinois Prescription Monitoring Program website by the physician and APRN with FPA. At least monthly, the APRN and physician must discuss the condition of any patients for whom an opioid is prescribed. Prescribing up to a 120-day initial supply of benzodiazepines is authorized without a consultation relationship with a physician; thereafter, continued prescription of benzodiazepines requires a consultation with a physician.

APRNs without FPA may have delegated prescriptive authority including for Schedules II-V CSs, which could be authorized by clinical privileges in a hospital, a hospital affiliate, or ASTC or which may be delegated to an APRN by a physician or podiatric physician as part of the written collaborative agreement during the TTP period. The collaborating physician or podiatric physician must have a valid, current Illinois CS license and federal registration. The APRN must apply for a mid-level practitioner CS license.

REIMBURSEMENT

The Illinois Department of Healthcare and Family Services (HFS) administers the Illinois Medicaid program. APRNs 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, APRNs must also enroll as providers for each Medicaid MCO of which any of their patients are members. Statutory prohibition for third-party reimbursement to APRNs does not exist. APRNs receive direct or indirect reimbursement from some third-party payers.

Indiana

https://www.in.gov/pla/professions/nursing-home
https://capni.enpnetwork.com

PRACTICE AUTHORITY

The Indiana State BON grants authority to and regulates APRNs, defined in IC 25-23-1-1 as including CNP ("NP" in regulation), CNM, CNS, and CRNA roles. The BON does not issue additional, separate licenses or certification to NPs or CNSs; however, CNMs apply for "limited licensure" to practice in that role. APRNs, except CRNAs, practice in collaboration with a licensed physician under a written practice agreement defined in 848 IAC 5-1-1 (a)(7); practice by privileges granted by the governing board of a hospital licensed under IC 16-21 (hospitals) with the advice of the medical staff of the hospital that sets forth the manner in which an APRN and a licensed practitioner will cooperate, coordinate, and consult with each other in the provision of health care to their patients; or practice by privileges granted by the

governing body of a hospital operated under IC 12-24-1 (state hospitals) that sets forth the manner in which the APRN and a licensed practitioner will cooperate, coordinate, and consult with each other in the provision of healthcare (IC 25-23-1-19.4). SOP is defined in regulation 848 IAC Article 4. The AANP considers NP practice in Indiana to be reduced practice.

APRNs seeking prescriptive authority must obtain approval by the BON; complete a graduate, postgraduate, or doctoral APRN program; hold national board certification in their APRN role; and submit proof of a written practice agreement with a licensed practitioner (physician, dentist, podiatrist, or optometrist). APRNs receive an identification number upon receipt of prescriptive authority for legend drugs. To prescribe CSs, APRNs must obtain Indiana Controlled Substances Registration and DEA registration. NPs are authorized to prescribe legend drugs to patients receiving care via telemedicine if they have established a provider-patient relationship and satisfy the standard of care and standard of documentation. CRNAs are not required to obtain prescriptive authority to administer anesthesia.

Opioid prescribing legislation (IC 25-1-9.7) limits initial opioid prescriptions for adults and all opioid prescriptions for children to 7 days. Exemptions include prescriptions for the treatment of cancer, the provision of palliative care, or the provision of MAT for substance use disorder; exemptions may also be made based on provider judgment or may be adopted for other conditions by medical licensing board rule.

REIMBURSEMENT

APRNs may receive third-party reimbursement as determined by payers. NPs receive Medicaid reimbursement at 85% of the physician payment; Medicaid managed care and fee-for-service plans must reimburse both NPs and CNSs employed by community mental health centers for services as specified.

Iowa

www.nursing.iowa.gov
https://iowanpsociety.enpnetwork.com

PRACTICE AUTHORITY

The Iowa BON regulates the licensure, education, and practice of APRNs, which are defined as advanced registered nurse practitioners (or ARNPs) in regulation and which include CNPs, CNSs, CNMs, and CRNAs (Iowa Administrative Code [IAC] 481-621.1 - 621.2). SOP is defined in IAC 481-621.4 and pertains to all ARNPs, regardless of role. ARNPs practice autonomously upon licensure and national certification within their specified role and population focus, as broadly defined in IAC 481-621. NP practice in the state of Iowa is considered full practice by the AANP.

ARNPs are statutorily recognized as PCPs and may hold hospital clinical privileges. Licensure as an ARNP requires active licensure as an RN, graduation from an accredited graduate or postgraduate advanced practice educational program, and certification issued by a national professional certification organization as a CNM or CRNA, or as a CNP or CNS in at least one population focus, including such areas as women's health/gender-related, family (individual across the lifespan), psychiatric mental health, adult/gerontology, pediatrics, or neonatal care.

ARNPs licensed by the BON are granted full prescriptive authority within their specific role and population focus. ARNPs may prescribe, administer, or dispense prescriptive devices or drugs, including CSs. ARNPs are required to complete a minimum of 2 contact hours of CE regarding the CDC guideline for prescribing opioids for chronic pain every 2 years and must query the Iowa Prescription Monitoring Program database prior to prescribing or dispensing an opioid, with some exceptions (IAC 481-621.6 and 481-621.7).

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 via third-party reimbursement if the policy or contract would pay for the care and treatment when provided by a physician. 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.

Kansas

https://ksbn.kansas.gov
https://kapn.enpnetwork.com

PRACTICE AUTHORITY

Kansas APRNs are licensed and regulated by the BON, with APRN title protection for the CNP, CNS, CNM, and CRNA roles. APRN SOP is defined in Kansas Administrative Regulations (KAR) 60-11-101, with additional detail on individual APRN roles in KAR 60-11-104 to 60-11-107. APRNs enjoy full practice authority and the AANP recognizes Kansas as an FPA state. All APRN applicants for licensure must hold a master's degree or higher in nursing and national board certification for initial and continuing licensure.

APRNs are not recognized as PCPs in Kansas. No specific language in statute authorizes or prohibits hospital privileges and admitting, and hospital privileges are determined by individual institution policy and procedure.

In 2025, Kansas Statutes Annotated (K.S.A.) 65-1158 was amended, authorizing CRNAs to prescribe DME and to prescribe, procure, and administer any drug consistent with the CRNA's education and qualifications, including Schedules II-V CSs in accordance with the uniform controlled substances act. This new authority aligns more closely with CNP, CNS, and CNM full prescriptive authority; however, CRNAs are not authorized to dispense medications.

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 rate (except for practitioners performing early periodic screening, diagnosis, and treatment, who receive 100%). CRNAs receive 85% of the physician payment. Some insurance companies pay 85% of the physician payment to APRNs.

Kentucky

https://kbn.ky.gov
www.kcnpnm.org

PRACTICE AUTHORITY

The Kentucky BON is authorized by statute to license APRNs and regulate their practice. APRNs are defined in statute 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. A collaborative agreement may be required for prescriptive authority, unless the APRN has been granted a statutory exemption.

APRN SOP is defined in Kentucky Revised Statutes (KRS) 314.011. APRNs are to seek consultation or referral in situations that are outside their SOP (201 Kentucky Administrative Regulations [KAR] 20:057 Section 3 (1)). APRNs are recognized as practitioners in statute (KRS 314.195) and included in the definition of "practitioner" for prescribing (KRS 217.015 (35) and KRS 218A.010 (40)). APRNs 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 Section 3(8)(f)2. b). A master's degree, doctorate, or postmaster's certificate as an APRN and national board certification are required to practice in Kentucky. The AANP considers Kentucky a reduced practice state.

APRNs must pass a jurisprudence exam for prescriptive authority to ensure that they are familiar with the requirements of obtaining and maintaining prescriptive authority for nonscheduled legend drugs and CSs. Pursuant to KRS 314.042, APRNs have autonomous prescriptive authority for nonscheduled legend drugs and CSs, respectively, following 4 years of prescribing experience under a "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Nonscheduled Legend Drugs" (CAPA-NS) and 4 years of prescribing experience under a "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Controlled Substances" (CAPA-CS). Both types of agreement require collaboration with a physician licensed in Kentucky. For an APRN to prescribe CSs in their first year of licensure, they are required to be employed by a healthcare entity or provider. If the employing provider is an APRN, the employing APRN must have been granted a CAPA-CS exemption, generally meaning that they must have completed 4 years of prescribing with a CAPA-CS and must no longer be required to maintain a CAPA-CS (KRS 314.042 (15) (l) and 201 KAR 20:057). CRNAs are not required to have a collaborative agreement with a physician to deliver anesthesia care.

Prescribing Schedules II-V CSs is authorized pursuant to a CAPA-CS. The CAPA-CS is required to be maintained for 4 years, after which time the APRN may request a review by the Kentucky BON to determine whether the APRN's license is in good standing in order to obtain independent prescriptive authority for CSs. Until review by the Kentucky BON is completed and independent prescriptive authority is granted, the APRN must continue to maintain a CAPA-CS agreement (KRS 314.042 [17] [b]). The CAPA-CS and CAPA-NS define an APRN's scope of prescriptive authority and must be signed by the APRN and the physician.

Kentucky limits all prescribers to a 72-hour (3-day) supply of Schedule II CSs when prescribing for acute pain, with certain exceptions defined in KRS 218A.205 (3)(b).

APRNs face other limitations when prescribing CSs. Specifically, prescriptions issued by APRNs for Schedule II CSs are limited to a 72-hour supply without any refill, with the exception that prescriptions for defined hydrocodone combination products are limited to a 30-day supply without refills and that certified psychiatric-mental health APRNs may prescribe a 30-day supply of psychostimulants. In addition, prescriptions issued by APRNs for Schedule III CSs are limited to a 30-day supply without refills, and Schedules IV and V CSs may be prescribed with refills not to exceed a 6-month supply (KRS 314.011(8)).

APRNs are authorized to request, receive, and 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.

REIMBURSEMENT

The state medical assistance program reimburses APRNs for services at 75% of the physician rate in all state regions (907 KAR 1:104 Section 2(2)(b)). Kentucky is an "any willing provider" state. In Kentucky, 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.

Louisiana

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

PRACTICE AUTHORITY

The Louisiana State BON regulates the practice, licensure, and education of APRNs. The APRN title is defined in

regulation and includes CNP, CNM, CRNA, and CNS roles. The authorized SOP for APRNs is defined in regulation, must be consistent with the APRN's educational preparation, and authorizes medical diagnosis and management in collaboration with a physician or dentist under a CPA. The CPA is a formal written statement addressing the parameters of the collaborative practice that are mutually agreed upon by the APRN and one or more collaborating physicians or dentists and that include consultation or referral availability, clinical practice guidelines, and patient coverage. PMHNPs and other NPs who act in accordance with a CPA are authorized to prepare and execute orders for the formal voluntary admission or noncontested admission of patients to licensed psychiatric hospitals. APRNs are authorized to hold hospital privileges.

APRNs must be licensed as an RN, possess a master's degree or higher, and either be certified by a national certifying body recognized by the BON or meet commensurate requirements if certification is not available. The AANP considers NP practice in Louisiana to be reduced practice.

The BON has sole authority to develop, adopt, and revise R&R governing SOP, including prescriptive authority. Prescriptive authority for APRNs includes the prescription of legend drugs and Schedules II-V CSs as well as the receipt and distribution of sample and prepackaged drugs including CSs. An APRN who is granted limited prescriptive authority may request approval to prescribe and distribute CSs as agreed upon by the APRN's collaborating physician if there is an identified need for CSs within the patient population served by the collaborative practice.

All medical practitioners are limited to prescribing a 7-day supply of opioid medication when issuing a first-time prescription for outpatient use to an adult with an acute condition and when issuing any opioid prescription for a minor. Exceptions to the limitation are provided for in law. APRNs are prohibited from prescribing CSs for the treatment of obesity and chronic or intractable pain.

LAC 46:XLVII:4513 provides for CRNA prescriptive authority without a CPA when prescribing or writing orders in a hospital or other licensed surgical facility for services related to anesthesia care. Rules continue to require a CPA for prescriptive authority of non-CRNA APRNs.

REIMBURSEMENT

State law prohibits qualified plans from excluding direct reimbursement of healthcare services provided by an APRN. In Louisiana, Medicaid recognizes CNPs, CNSs, and CNMs as PCPs and recognizes those APRNs as the PCP or "medical home" under certain circumstances. APRNs are reimbursed at 80% of the physician rate 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.

Maine

www.maine.gov/boardofnursing
www.mnpa.org

PRACTICE 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 either must practice for at least 24 months under the supervision of a licensed physician or an NP or they must be employed by a clinic or hospital that has a medical director who is a licensed physician. CRNAs are responsible and accountable to a physician or dentist except for services provided in critical access or rural hospitals, and they are authorized to order appropriate lab and diagnostic imaging tests in the perioperative 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 health care needs." Psychiatric and mental health CNPs and certified PCNSs may sign documents for emergency, involuntary commitment through EDs. CNPs are authorized to provide certification for patients for medical use of marijuana for therapeutic or palliative benefit. The AANP considers Maine to be a full practice state.

A hospital governing body has the authority, in accordance with state law, to grant medical staff privileges and membership to nonphysician practitioners. CNPs are authorized to complete forms for workers' compensation and for the issuance of license plates and cards for individuals who are physically disabled.

CNPs and CNMs may prescribe and dispense drugs or devices, in accordance with rules adopted by the BON, including Schedules II-V CSs and FDA-approved drugs related to the clinician's specialty. CNPs and CNMs may also prescribe Schedules II-V CSs and other drugs off-label, according to common and established standards of practice. CNPs and CNMs may receive and distribute drug samples.

CRNAs are authorized to order and prescribe medication during the preoperative and immediate postoperative periods. CRNAs may prescribe Schedules III-V CSs with a DEA-issued number registered under a verified critical access or rural hospital address for a supply of 4 or fewer days without refills and only for an individual who is an established client or patient of record.

All APRNs must successfully complete 3 hours of CE every 2 years on prescribing opioids as a condition of prescribing these medications (Public Law, Chapter 488).

REIMBURSEMENT

When referred by a PCP, state law requires reimbursement to NPs and CNMs from indemnity or managed care plans. Additionally, insurers are required to assign separate provider ID numbers and authorize managed care enrollees to designate a CNP as their PCP. However, MCOs are not

required to credential any physician or CNP if their access standards have not 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 reimburse independent CNPs. Medicaid reimburses in full for services provided by certified FNPs and PNPs and reimburses CNMs on a fee-for-service basis.

Maryland

https://health.maryland.gov/mbon/pages/default.aspx
www.npamonline.org
https://maapconline.enpnetwork.com/

PRACTICE AUTHORITY

The Maryland BON regulates APRN practice, defining APRNs in regulation (Code of Maryland Regulations [COMAR] 10.27.07.01). The APRN title includes the CNP ("NP" or "CRNP" in statute), CRNA, CNM, and CNS roles. NP SOP is defined in statute and regulations in accordance with the AANP's Standards of Practice for Nurse Practitioners. The AANP considers NP practice in the state of Maryland full practice.

Applicants for initial certification as an NP in Maryland who have never been certified in Maryland or any other state are required to name a mentor (an NP or physician licensed in Maryland) upon application to the BON. The mentor must be available for advice, consultation, and collaboration as needed for 18 months beginning on the date of application. CRNAs maintain an affirmation of collaboration with the BON containing the name and license number of an anesthesiologist, physician, or dentist; however, there is no direct supervision requirement. To enter practice in Maryland, a master's level or higher degree and national board certification are required.

All APRNs have full prescriptive authority, including for Schedules II-V CSs. In addition to DEA registration, all APRNs are required to obtain state Controlled Dangerous Substances registration before they can prescribe CSs. NPs and CNMs who hold a state Controlled Dangerous Substances registration, registration with the Maryland Cannabis Administration, and are in good standing with the state BON may issue written certification for medical marijuana use to qualifying patients. CNPs are legally authorized to prepare and dispense medications, including CSs, in occupational health facilities, nonprofit clinics or health facilities, student health clinics within institutions of higher education, public health facilities, and nonprofit hospitals or nonprofit hospital outpatient facilities.

REIMBURSEMENT

All APRNs are entitled to private third-party and Medicaid reimbursement for services if they are practicing within their legal SOP. All individuals enrolled in Medicaid are assigned to an MCO; primary care and psychiatric-mental health CNPs and CNMs are designated PCPs and may apply for placement on a provider panel. Medicaid reimburses at 100% of the physician payment rate.

The law does not require that an HMO include CNPs on their panel as PCPs; however, APRNs have due process and are not to be arbitrarily denied. Several commercial insurers reimburse NPs directly, generally at a rate of 75% to 85% of a physician's fee schedule.

Massachusetts

www.mass.gov/dph/boards/rn
www.mcnpweb.org

PRACTICE AUTHORITY

The Massachusetts BON grants APRNs the authority to practice and regulates their practice. APRN roles include CNPs, CRNAs, psychiatric nurse mental health clinical specialists (PNMHCSs), CNSs, and CNMs. APRNs enjoy FPA with a TTP for full prescriptive authority. SOP for all APRNs is consistent with the scope and standards of their APRN practice for which they are nationally certified, which is defined within the BON R&Rs. CNPs are authorized to issue written certifications for medical marijuana use within their SOP. The AANP recognizes Massachusetts as a full practice state.

Massachusetts recognizes CNMs and CNPs as PCPs. Credentialing for hospital privileges varies according to hospital policies. Massachusetts mandates a minimum of a graduate degree for initial (not reciprocal) APRN authorization. APRNs who obtained certification prior to December 31, 2016 who do not have a graduate degree may be eligible by reciprocity. National certification is required to enter and remain in practice.

Massachusetts state law provides for prescriptive authority for CNPs, CNMs, CRNAs, and PNMHCSs, including of Schedules II-VI CSs. Authorized APRNs must apply to the state's Department of Public Health for Massachusetts Controlled Substances Registration in addition to the DEA for DEA registration. CNPs, CRNAs, and PNMHCSs with less than 2 years of supervised practice must establish written guidelines in collaboration with the supervising qualified healthcare professional. Written guidelines include a defined mechanism to monitor prescribing practices and must designate a qualified healthcare professional, as defined in 244 Code of Massachusetts Regulations (CMR) 4.07, who will provide supervision for prescriptive practice.

For APRNs in supervised practice, the name of the supervising qualified healthcare professional must be included on the prescription in addition to the name of the CNP, CRNA, or PNMHCS; however, the APRN is authorized to sign the prescription. Authorized APRNs may request, receive, and dispense pharmaceutical samples.

All prescribers are required to complete education relative to effective pain management, risks of misuse and

addiction associated with opioid use, identification of patients at risk for substance misuse, patient counseling, appropriate prescription quantities, and use of opioid antagonists and opioid overdose prevention treatments prior to obtaining or renewing their professional licenses (Massachusetts General Law [M.G.L.], Part I, Title XV, Chapter 94C, Section18(e)).

REIMBURSEMENT

FNPs, PNPs, and adult NPs are reimbursed at 100% of the physician payment rate for Medicaid unless employed by the hospital in a hospital-based practice. Massachusetts state law mandates reimbursement to NPs, PNMHCSs, CNMs, and CRNAs in accordance with Chapter 302 of the Acts and Resolves of 1994. These include indemnity plans, nonprofit hospital corporations, medical service corporations, and HMOs. Under Massachusetts state law, a CNP can be recognized and deliver care as a PCP and carriers must allow patients to choose a CNP as their PCP.

Michigan

www.michigan.gov/lara/bureau-list/bpl/health/hp-lic-health-prof/nursing
www.micnp.org

PRACTICE AUTHORITY

The Michigan BON grants APRN practice authority and regulates APRN practice. APRNs are defined in statute and include the CNP, CNS, and CNM roles. CRNAs ("NAs" in statute) are recognized by the BON and granted specialty certification but are not categorized as APRNs in statute. Although no statute exists requiring supervision or collaboration to practice apart from the delegation of prescriptive authority for scheduled medications, the state has interpreted CNP practice as "supervised" due to the CNP's ability to "diagnose," which is defined as the practice of medicine. 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 them. APRN SOP is not defined within statute and thus is considered the RN SOP plus tasks that can be delegated by another licensee, typically a physician. Under some HMOs and systems, CNPs are recognized as PCPs. Michigan statute does not specifically authorize APRNs to admit patients or hold hospital privileges; however, hospitals generally grant these privileges. APRNs are required to have a graduate degree in nursing and national board certification to practice. NP practice in the state of Michigan is considered by the AANP to be restricted.

APRNs are authorized to prescribe nonscheduled prescription drugs; prescribing Schedules II-V CSs is authorized as a delegated act of a physician and must include the APRN's and physician's names and DEA numbers. APRNs may order, receive, and dispense nonscheduled complimentary starter dose drugs independently; however, delegation by a physician is required to order, receive, and dispense complimentary starter doses of Schedules II-V CSs.

REIMBURSEMENT

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

Minnesota

https://mn.gov/boards/nursing
www.mnnp.org
https://mnaprnc.enpnetwork.com

PRACTICE AUTHORITY

The Minnesota BON grants APRNs the authority to practice through licensure and regulates their practice. APRNs are defined in statute (Minnesota Statutes, Section 148.171, Subd. 3) and include the CNP, CNS, CNM, and CRNA roles. APRNs are granted FPA. SOP is defined in statute and must be consistent with the APRN's education. APRNs are authorized to enroll in the Medical Cannabis Registry to certify qualifying conditions for medical cannabis. 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 (Minnesota Statutes, Section 148.211, Subd. 1c). CRNAs and CNMs do not have a postgraduate practice requirement.

APRNs are not prohibited from holding hospital privileges including admitting 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. NP practice in Minnesota is considered full practice by the AANP.

Licensed APRNs may independently prescribe, receive, dispense, and administer drugs, including Schedules II-V CSs. CRNAs must hold a verbal agreement with a physician when providing nonsurgical pain therapies for acute pain and a written prescribing agreement with a physician when providing nonsurgical pain therapies for chronic pain symptoms. APRNs must register their DEA number with the BON, and they have statutory authority to request, receive, and dispense sample medications. All Minnesota APRNs who hold DEA registration must register and maintain an account with the Prescription Monitoring Program.

REIMBURSEMENT

APRNs may enroll with Medicaid as providers and bill for services. Enrolled CRNAs, CNSs, and CNPs are

reimbursed by Medicaid at 90% of the physician rate and enrolled CNMs at 100% 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 co-signature when an APRN orders a lab test, radiograph, or diagnostic test.

Mississippi

www.msbn.ms.gov
www.msanp.org

PRACTICE AUTHORITY

The Mississippi BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP, CNM, and CRNA roles. SOP is defined and regulated by the BON, and APRNs practice in a collaborative relationship with physicians; however, APRNs must satisfy a monitored practice hour requirement prior to practicing in a site. RNs with less than 1 year (2,000 hours) of experience, must have 2,000 hours of monitored APRN practice. RNs with more than 1 year (2,000 hours) of experience must complete 1,000 hours of monitored APRN practice. The practice hour requirement may be monitored by a physician, dentist, and/or APRN who has a minimum of 3 years of active practice experience and similar preparation. APRNs practice according to a BON-approved protocol agreed on by the APRN and physician (Title 30 of the MS Administrative Code: Part 2840, Chapter 1; Rule 1.3 and Rule 1.4). Practicing in a site not approved by the BON is in violation of the NPA R&R. CNPs practicing within the VA system have FPA. The AANP considers NP practice in Mississippi to be reduced practice.

CNPs are statutorily recognized as PCPs. APRNs are legally authorized to admit patients and hold hospital privileges. APRNs must have a master's degree or higher in nursing, nurse anesthesia, or midwifery as well as national certification for licensure to practice in Mississippi.

APRNs have full prescriptive authority, including prescription of Schedules II-V CSs, based on the standards and guidelines of the APRN's national certification organization and a BON-approved CS prescriptive authority protocol that has been mutually agreed on by the APRN and qualified physician. APRNs may receive and distribute prepackaged sample medication for which they have prescriptive authority (Title 30 of the MS Administrative Code: Part 2840, Chapter 1; Rule 1.5).

REIMBURSEMENT

Medicaid reimbursement is available to APRNs at 85% of the physician rate. Insurance law specifies that whenever an insurance policy, medical service plan, or hospital service contract provides reimbursement for any service within the SOP of a CNP working in collaboration with a physician, the insured will be entitled to reimbursement whether the services are performed by the physician or NP.

Missouri

www.pr.mo.gov/nursing.asp
https://amnp.enpnetwork.com

PRACTICE AUTHORITY

The Missouri BON grants APRNs the authority to practice and regulates their practice. APRNs are defined in statute and regulation and include CNP, CNS, CNM, and CRNA roles. SOP is defined in regulation and must be within the professional scope and standards of the individual's APRN role and population focus, consistent with their formal education and national certification, and in accordance with regulations set forth by state and federal agencies for CS prescribing.

APRNs practice in collaboration with a physician as set forth in 20 Code of State Regulations (CSR) 2200-4.200 Collaborative Practice (CP) rule. Two focus areas in the CP rule include 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 required 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 when consistent with the APRN's skill, training, education, and competence. CRNAs practice under the supervision of an anesthesiologist or other physician, dentist, or podiatrist and are not required to have a CP arrangement. When practicing outside their recognized clinical nursing specialty, APRNs must practice and title as RNs only. The AANP considers NP practice in Missouri to be restricted practice.

Missouri law does not recognize APRNs as PCPs, and 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 practice in Missouri.

Application for CS prescriptive authority is authorized following 1,000 hours of postgraduate clinical experience in the CNP, CNS, or CNM role. A Missouri Bureau of Narcotics and Dangerous Drugs number, in addition to DEA registration, is required. Prescriptive authority for CNPs, CNSs, and CNMs includes prescription drugs/devices, Schedules III-V CSs, Schedule II hydrocodone-containing CSs, and buprenorphine as delegated by a physician pursuant to a written CP arrangement, when it is within the APRN's specialty area and consistent with the individual's skill, training, education, and competence.

A collaborative practice arrangement may delegate to an APRN the authority to administer, dispense, or prescribe Schedule II CSs for patients receiving hospice services; provided, that the APRN is employed by a hospice provider certified pursuant to chapter 197 and the APRN is providing care to patients receiving hospice services pursuant to a collaborative practice arrangement that designates the certified hospice as a location where the APRN is authorized to practice and prescribe.

REIMBURSEMENT

APRN services are required to be reimbursed by any health insurer, nonprofit health service plan, or HMO, if such services are within the APRN's SOP. 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.

Montana

https://boards.bsd.dli.mt.gov/nursing
www.mtnurses.org

PRACTICE AUTHORITY

The Montana BON grants APRNs authority to practice and regulates their practice. The APRN title is defined in regulation and includes the CNP, CNS, CNM, and CRNA roles. APRN SOP is defined in Administrative Rules of Montana (ARM) 24.159.1405 and ARM 24.159.1406, and according to the Montana BON, all APRNs are expected to engage in ongoing competence development per ARM 24.159.1469. APRNs are legally authorized to admit patients and hold hospital privileges; however, this varies according to the rules and bylaws of each hospital. The AANP considers NP practice in Montana to be full practice.

APRNs must have a graduate-level degree or postgraduate certificate from an accredited APRN program and hold national certification to practice. APRNs may only practice in the role and population focus within which they are nationally certified. 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 their ongoing competence development.

APRNs who desire prescriptive authority must apply for recognition by the BON. APRNs with prescriptive authority are independently authorized to prescribe all medications, including Schedules II-V CSs, and are permitted to request, receive, and dispense drug samples.

REIMBURSEMENT

Medicaid reimburses APRNs at 85% of the 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 federal guidelines is in effect. APRNs are included as providers for workers' compensation.

Nebraska

https://dhhs.ne.gov/licensure/Pages/Nurse-Licensing.aspx
www.nebraskanp.org

PRACTICE AUTHORITY

The Nebraska Board of Advanced Practice Registered Nursing grants APRNs the authority to practice and regulates their practice. APRNs include CNP ("NP" in statute), CNS, CNM, and CRNA roles. Effective July 1, 2026, APRN practice will be governed completely by the BON, which will increase APRN representation on the BON to 4. A TTP agreement entailing 2,000 hours of initial collaborative practice between the NP and a supervising provider is required in Nebraska. The TTP period may be supervised by an experienced physician or an NP with 10,000 hours of practice, as defined in Nebraska Revised Statute 38-2322. An NP's SOP is defined in Nebraska Revised Statute 38-2315 and occurs within the specialty area through health promotion, health supervision, illness prevention and diagnosis, treatment, and management of common health problems and acute and chronic conditions. The AANP considers NP practice in the state of Nebraska to be full practice.

CNMs continue to practice in collaboration with a licensed practitioner as defined and as specified within a practice agreement reviewed and approved by the Board. CRNAs are authorized to determine and administer total anesthesia care as described in consultation and collaboration with a licensed physician or osteopathic physician. 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 practice.

Prescriptive authority is granted to NPs, CRNAs, and CNMs at the time of licensure in alignment with health conditions contained within their respective SOPs. Pursuant to Nebraska Revised Statute 38-2315 (2) (a – c), NPs are granted full prescriptive authority within their SOP. NPs may request, receive, and dispense pharmaceutical samples if the samples are of drugs within their prescriptive authority. CRNAs prescribe within their specialty practice, and authority is implied in the statute. CNSs do not have prescriptive authority in Nebraska.

REIMBURSEMENT

State legislation mandating third-party reimbursement for NPs does not exist; consequently, some NPs have been refused recognition as providers. BC/BS reimburses APRNs at 85% of the physician rate. Medicaid reimburses NPs at 100% of the physician rate. Board-certified primary care NPs or NPs who specialize in family practice, internal medicine, or pediatrics are listed as direct providers and are

reimbursed for services under the Direct Primary Care Agreement Act.

Nevada

https://nevadanursingboard.org
https://napna.enpnetwork.com

PRACTICE AUTHORITY

The Nevada BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP ("NP" in statute), CNS, and CNM roles. APRNs practicing for 2 years (or 2,000 hours) are granted FPA. APRN SOP is defined in the NPA and includes the nationally established scope and standards for the APRN role as well as global signature authority. The AANP considers NP practice in the state of Nevada to constitute full practice.

Nevada requires a master's or doctorate degree in nursing and national board certification for APRN licensure since 2014. Those certified prior to that year have fewer requirements (Nevada Administrative Code [NAC] 632.260). APRNs may hold membership on the medical staff of a hospital and have authority to admit and care for patients in a hospital setting. APRNs are not recognized as PCPs under Nevada state law.

BON-authorized APRNs with FPA may prescribe Schedules II-V CSs, poisons, and dangerous drugs and devices when authorized by the BON and provided on application a certificate of registration by the BOP. A collaborative agreement and protocols with a physician are only required for APRNs with fewer than 2 years or 2,000 hours of experience and only if they wish to prescribe Schedule II CSs. To receive dispensing privileges, APRNs must pass a dispensing exam issued by the BON and then apply to and be granted an APRN dispensing registration by the BOP.

REIMBURSEMENT

APRNs are recognized by insurance companies and receive third-party reimbursement. APRNs receive Medicaid reimbursement parity with physicians for performing the same service.

New Hampshire

www.oplc.nh.gov/new-hampshire-board-nursing
www.nhnpa.org

PRACTICE AUTHORITY

The New Hampshire BON grants APRNs authority to practice and regulates their practice in the state. APRNs include CNPs, CNMs, and CRNAs. APRNs in New Hampshire enjoy FPA, per the AANP, with their SOP defined in statute, and they 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 practice is a master's degree in nursing, and national certification by a BON-recognized certification agency is also required.

BON-licensed APRNs have plenary authority to possess, compound, prescribe, administer, dispense, and distribute controlled and noncontrolled medications within the scope of their practice. APRNs are authorized to request, receive, and dispense pharmaceutical samples. All prescribers with DEA registration are also required to register with the PDMP and complete the required contact hours of regulatory board-approved online CE or pass an online exam in the areas of pain management, addiction disorder, or a combination.

REIMBURSEMENT

All major insurance companies, hospital service corporations, medical service corporations, and nonprofit health service corporations must reimburse APRNs when the insurance policy covers any service that may be legally performed by the APRN and such service is rendered by the APRN. Provider Contract Standards (New Hampshire Statutes, Title XXXVII, Section 420-J:8 VIII (f)) were added, prohibiting health carriers from establishing payment or reimbursement provisions based solely on a participating APRN's license. APRNs are recognized as PCPs by all HMOs in the state. Medicaid reimburses APRNs at 100% of the physician payment.

New Jersey

www.njconsumeraffairs.gov/nur/Pages/default.aspx
https://apnnj.enpnetwork.com

PRACTICE AUTHORITY

The New Jersey BON grants APRNs authority to practice and regulates their practice. APRNs are referred to in the NPA as "APNs" and include CNP, CNS, and CRNA roles; CNMs are regulated by the New Jersey BOM. APN SOP is defined in statute, with joint protocols with a collaborating physician required for prescribing drugs and devices only. According to the AANP, NP practice in New Jersey is considered reduced practice.

In New Jersey, APNs are recognized as PCPs and are authorized to admit patients and hold hospital privileges through the credentialing/privileging process of individual healthcare institutions. APN applicants must be master's-prepared in nursing, and national board certification is required to enter practice in New Jersey.

APNs credentialed by the BON have full prescriptive authority, including for prescription of Schedules II-V CSs, in accordance with a joint protocol established between an APN and a collaborating physician. The joint protocol is required for prescribing drugs and devices only and is not a collaborative agreement for general practice. To prescribe CSs, APNs must have both a state Controlled Dangerous Substance (CDS) number and DEA registration and must

have modified the joint protocol to indicate whether prior consultation with the collaborating physician is necessary before initiating CDS prescriptions. In addition to basic pharmacology education requirements for APN certification, all APNs must complete a one-time, 6-hour course in CS prescribing, including coverage of addiction prevention and management, by an approved/accredited organization. APNs are authorized to request, receive, and dispense pharmaceutical samples.

REIMBURSEMENT

Private health plans, including Medicaid managed care plans, are permitted to credential APNs as PCPs but not required to recognize or reimburse them. After 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, NJ FamilyCare/Medicaid, United Healthcare, and other Medicaid HMOs, including Cigna, Great West, Health Net, Amerigroup, QualCare, and Oxford. Direct reimbursement to APNs is also provided by the Civilian Health and Medical Program (for care of uniformed service members and their families). If APNs are credentialed and directly reimbursed by private insurers, it is generally at 85% of the physician rate, mirroring Medicare.

Aetna, Horizon BC/BS, and some Horizon MCOs will only credential and reimburse APNs who work in physician practices; they do not credential and reimburse APNs recognized as ILPs who provide primary care. Both Aetna and Horizon have consistently credentialed and directly reimbursed psychiatric APNs.

New Mexico

www.bon.nm.gov
www.nmnpc.org

PRACTICE AUTHORITY

The New Mexico BON grants APRNs the authority to practice and regulates their practice. In New Mexico, the APRN profession includes CNP, CNS, and CRNA roles. CNP, CNS, and CRNA SOP is defined in Chapter 61, Article 3 of the New Mexico Statutes. APRNs are statutorily recognized as PCPs when providing care within their SOP in several areas of New Mexico law. CNMs are regulated by the Department of Health and are recognized as PCPs in statute. CNPs, CNSs, and CNMs have hospital admitting and discharging privileges, and they may hold membership on medical staff committees in parity with physician privileges. A master's degree in nursing or higher and national board certification are required to enter practice as a CNP or CNS. CRNAs seeking initial licensure must hold a master's degree or higher and now have independent practice privileges. CRNAs may be required to maintain an interdependent relationship with a physician according to facility rules. According to the AANP, New Mexico is a full practice state.

CNPs and CNSs have full, independent prescriptive authority, inclusive of Schedules II-V CSs, within the scope of their specialty practice and setting. A current state CS registration and DEA number are required unless the CNP or CNS has met registration waiver criteria from the New Mexico BOP. CNPs and CNSs with prescriptive authority may distribute dangerous drugs and Schedules II-V CSs that have been prepared, packaged, or prepackaged by a pharmacist or pharmaceutical company.

CRNAs who meet prescriptive authority requirements may collaborate as needed and prescribe and administer therapeutic measures, including dangerous drugs and CSs, within emergency procedures, perioperative care, or perinatal care environments. CRNAs must adhere to the current formulary approved by the BON.

CNM licensure and prescriptive authority are issued pursuant to the rulemaking authority of the Department of Health.

REIMBURSEMENT

Statutory authority for third-party reimbursement for CNPs 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. Effective January 1, 2025, NPs receive Medicaid reimbursement at 100% of the physician payment. All three of the managed care groups contracted to provide Medicaid coverage in New Mexico have contracts with CNPs.

New York

https://www.op.nysed.gov/nurse-practitioners
www.thenpa.org

PRACTICE AUTHORITY

The New York State Education Department Office of Professions certifies and registers NPs and CNSs to practice in their state. The term "APRN" is not defined in New York statutes or regulation. NP SOP is defined in Title 8, Chapter II, Subchapter B, Part 64 of the New York Codes, Rules and Regulations (NYCRR), with NPs authorized to diagnose illnesses and physical conditions, including ordering diagnostic tests, and to perform therapeutic and corrective measures within the specialty areas of practice in which they are certified. CNS SOP is defined as the practice of professional nursing. As of the time of writing, New York requires all NPs with less than 3,600 hours of experience to practice in collaboration with a licensed physician in the NP's practice area pursuant to a written practice agreement and practice protocols. NPs with more than 3,600 hours of experience are not required to comply with the requirements relating to collaboration with a physician, written practice agreements, and written practice protocols. As of the time of writing, this statute is due to sunset on July 1, 2026. New York meets the AANP's standards for FPA.

NPs are legally authorized to hold admitting privileges. Certification as an NP in New York requires completion of an educational program/master's degree in nursing registered with the New York State Education Department (or equivalent, as determined by the Department), current certification by a national certifying body approved by the Department, or current licensure/certification as an NP elsewhere with similar standards to New York.

CNMs are not regulated or recognized by the BON; however, they practice in a collaborative relationship with a physician and must complete a master's or higher degree program in midwifery or a related field that is accredited by the Accreditation Commission for Midwifery Education or determined by the Department to be equivalent to an accredited program.

The role of the CRNA is not regulated or recognized by the NY BON; however, CRNAs provide anesthesia in collaboration with surgeons, anesthesiologists, dentists, podiatrists, and other qualified healthcare professionals. When anesthesia is administered by a nurse anesthetist in New York, it is recognized by the state as the practice of nursing.

NPs are authorized to prescribe or order medications, including Schedules II-V CSs, and may dispense medications to their patients within the practice agreement or practice protocols if applicable. CNMs are authorized to prescribe and administer drugs, immunizing agents, and diagnostic tests and devices as well as to order lab tests limited to the practice of midwifery; they may dispense pharmaceutical samples packaged or prepackaged by a pharmacist or pharmaceutical company.

REIMBURSEMENT

In New York, NPs can form and own private practices that provide NP services. NPs qualify as participating providers in New York's Medicaid program, Medicare program, and a variety of commercial managed care and insurance plans.

North Carolina

www.ncbon.com
https://ncnpn.enpnetwork.com

PRACTICE AUTHORITY

A joint subcommittee of the North Carolina BON and the North Carolina Medical Board grants NPs the authority to practice and regulates their practice. Both CRNAs and CNSs are solely regulated by the BON. CNMs are regulated by the Midwifery Joint Committee. "APRN" is defined in regulation and includes NP, CNS, CNM, and CRNA roles. NP SOP is defined in 21 North Carolina Administrative Code (NCAC) 36 .0802 as a broad range of personal health services for which educational preparation is established and for which competency has been maintained. Physician supervision and collaboration is required for NP practice. The parameters of the NP's practice are operationalized through a CPA, which must describe the arrangement for NP-primary supervising physician continuous availability to each other for the ongoing supervision, consultation, collaboration, referral, and evaluation of care provided by the NP. 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. The AANP considers North Carolina a restricted practice state.

Monthly quality improvement process meetings are required during the first 6 months of NP practice with a new primary supervising physician and then every 6 months thereafter. These meetings must be documented with NP and primary supervising physician signatures. State law does not prohibit NPs from having admitting privileges and hospital privileges; however, these are granted on a facility-by-facility basis. APRNs are authorized to form professional corporations or professional limited liability companies for providing nursing services.

CNMs are authorized to practice midwifery independently following approval by the Joint Committee. Independent practice follows completion of a 24-month and 4,000-hour TTP period in collaboration with a physician or CNM. A CNM with fewer than 24 months and 4,000 hours of practice must practice under a "collaborative provider agreement."

Eligibility requirements for licensure in all APRN roles include a current unencumbered RN license, graduate education in one of the state's four recognized APRN roles, and initial and ongoing national certification in the APRN's population focus. NPs have full prescriptive authority, including of Schedules II-V CSs identified in their CPA. Dispensing is authorized under specific conditions and only if a dispensing license has been obtained. In North Carolina, CNMs have full prescriptive authority, whereas CRNAs and CNSs do not have prescriptive authority.

The 2017 Strengthen Opioid Misuse Prevention (STOP) Act limits prescribers to a 5-day supply of any "targeted controlled substance" (General Statute [G.S.] 90-90(1), (2) and G.S. 90-91(d)) upon initial consultation and treatment for acute pain and to a 7-day supply of any targeted controlled substance for postoperative acute pain relief following a surgical procedure, with some exceptions. An NP must consult with a supervising physician prior to prescribing targeted CSs only when the patient is being treated by a facility that primarily engages in the treatment of pain by prescribing narcotic medications and the therapeutic use of the targeted CS will or is expected to exceed a period of 30 days. NPs must consult with the physician at least once every 90 days when a targeted CS is continuously prescribed to the same patient.

REIMBURSEMENT

NPs and 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.

North Dakota

www.ndbon.org
www.ndnpa.org

PRACTICE AUTHORITY

The North Dakota BON grants APRNs the authority to practice and regulates their practice. APRNs are defined in the NPA and include CNP, CNS, CNM, and CRNA roles. APRNs practice independently in North Dakota; their SOP is defined in regulation and must be consistent with their nursing education and advanced practice certification. The AANP considers NP practice in the state of North Dakota to be full practice. APRNs are statutorily recognized as PCPs.

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. They must also hold national certification in an advanced nursing role.

APRNs must apply to the BON for prescriptive authority and meet the requirements outlined in North Dakota Administrative Code 54-05-03.1-09. Authorized APRNs with prescriptive authority may prescribe, administer, sign for, and dispense OTC drugs, legend drugs, and CSs and may procure pharmaceuticals, including sample legend drugs and Schedules II-V CSs.

REIMBURSEMENT

FNPs and PNPs receive Medicaid reimbursement at 75% of the physician rate and CNMs at 85% of the physician rate. BC/BS reimburses CRNAs, CNMs, CNSs, and CNPs based on the lesser of the provider's billed charges or 75% of the BC/BS physician payment system in effect at the time services are rendered. All certified NPs are 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.

Providers practicing more than 20 miles from Williston, Dickson, Minot, Bismarck, Jamestown, Devils Lake, Grand Forks, Wahpeton, or Fargo are reimbursed the lesser of the provider's billed charges or at 85% of the BC/BS physician payment system in effect at the time services are rendered.

Ohio

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

PRACTICE AUTHORITY

The Ohio BON grants APRNs authority to practice and regulates their practice. The term "APRN" is defined in statute and includes the CNP, CNS, CNM, and CRNA roles. SOP is defined in statute and requires a standard care arrangement between a physician or podiatrist and a CNP, CNS, or CNM. Psychiatric-mental health CNPs and CNSs may only enter standard care arrangements with physicians practicing in psychiatry; pediatrics; family practice; or primary care. CRNA SOP is defined in statute as including evaluation, assessment, and prescriptive authority related to the administration of anesthesia when standards and procedures have been established within the healthcare facility. The AANP defines Ohio NP practice as reduced.

CNPs, CNSs, and CNMs are authorized to admit patients to a hospital if they have a standard care arrangement with a collaborating physician who is a member of the hospital's medical staff. 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 practice.

Prescriptive authority for CNPs, CNMs, and CNSs includes the ability to prescribe Schedules II-V CSs in collaboration with a physician. CNPs, CNSs, and CNMs must register with the Ohio Automated Rx Reporting System and access the database information as required, and they also must register with the DEA. APRNs prescribe based upon an exclusionary formulary recommended by the interdisciplinary Committee on Prescriptive Governance and adopted by the BON in administrative rule. By statute, prescriptive authority of the CNP, CNS, or CNM shall not exceed the prescriptive authority of their collaborating physician or podiatrist. These 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 CSs is limited to prescriptions issued from specific locations and programs recognized in Ohio nursing law and consistent with the APRN's standard care arrangement. Limitations are also placed on APRNs' prescribing of opioids for the treatment of acute, subacute, and chronic pain. Law authorizes APRNs to prescribe Schedule II CSs if the prescription is issued at a behavioral health practice and only if that practice provides outpatient services for mental health conditions and/or substance use disorders; in these cases, the APRN must be working with a collaborating physician employed at the same practice.

For APRNs not practicing in a location or program recognized in law, Schedule II CS prescribing is limited to situations in which all the following apply: a patient has a terminal condition, a physician initially prescribed the drug, and the prescription quantity is not more than a 72-hour supply. APRNs with prescriptive 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.

REIMBURSEMENT

Ohio's Medicaid program recognizes CNPs certified in family, adult, acute, geriatric, neonatal, pediatric, and women's health/obstetrics specialties. 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 APRN to be listed on managed care panels; insurance companies are statutorily mandated to reimburse CNMs. Workers' compensation continues to reimburse CNPs, CRNAs, and CNSs. Reimbursement is otherwise determined by the payer.

Oklahoma

https://oklahoma.gov/nursing.html
https://npofoklahoma.com

PRACTICE AUTHORITY

The Oklahoma BON grants APRNs the authority to practice and regulates their practice. The term APRN is defined in statute and includes the CNP, CNS, CNM, and CRNA roles. APRNs practice within an SOP as defined by the NPA, authorizing CNPs, CNSs, and CNMs to function independently except for prescriptive authority, which requires supervision by a physician. The Oklahoma Nursing Practice Act, 59 Oklahoma Statutes (O.S.) § 567.1, *et seq.*, was amended, authorizing CNPs, CNSs, and CNMs to apply for independent prescriptive authority recognition upon completion of 6,240 clinical hours under physician supervision, effective November 2025. The SOP for CNPs and CNSs further delineate specialty population foci. CRNAs function in collaboration with a medical doctor, osteopathic physician, podiatric physician, or dentist licensed in Oklahoma under conditions in which timely, on-site consultation by the collaborating provider is available; their collaborative practice is defined as joint formulation of, discussion of, and agreement on the anesthesia plan. The AANP defines Oklahoma NP practice as restricted.

CNPs are recognized as PCPs and hospital privileges are not expressly prohibited. Initial licensure as an APRN requires graduation from a graduate-level accredited APRN program and national certification consistent with educational preparation.

The BON regulates optional prescriptive authority for CNPs, CNSs, and CNMs, including for Schedules III, IV, and V CSs. Prior to completion of 6,240 clinical hours, prescriptive authority requires physician supervision, and APRNs with prescriptive authority must submit to the BON a written statement from an Oklahoma-licensed physician that identifies the mechanism for appropriate referral, consultation, and collaboration and the availability of communication between the APRN and physician.

All authorized APRNs may only prescribe according to an exclusionary formulary approved by the BON, must only prescribe within their SOP, and may only prescribe no more than a 30-day supply of Schedules III, IV, and V CSs, if Oklahoma Bureau of Narcotics and Dangerous Drugs Control (OBNDD) and DEA registrations are obtained.

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 CSs.

CNPs, CNSs, and CNMs must complete 2 hours of CE in pain management or 2 hours of education in opioid use or addiction, in addition to the 15 contact hours of pharmacotherapeutics, for renewal of prescriptive authority. CNPs, CNSs, and CNMs with independent prescriptive authority must complete 40 contact hours of Category 1 CME within the two-year period before renewal.

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 Group Insurance Board recognizes CNPs as providers. Negotiations continue with other third-party insurers. The Oklahoma BON does not regulate reimbursement.

Oregon

www.oregon.gov/OSBN
www.nursepractitionersoforegon.org

PRACTICE AUTHORITY

Oregon BON grants FPA to and regulates APRNs. APRNs are licensed by specialty type, including CNS, CRNA, and NP (inclusive of NPs specializing in Certified Nurse Midwifery -CNM). 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 but is utilized collectively to refer to NPs (including CNMs), CNSs, and CRNAs.

SOP in Oregon is defined in Oregon Administrative Rules (OAR) 851-055 and must align with the population focus of education and national certification exam content. APRNs can attest that patients meeting specific criteria qualify for the Oregon Medical Marijuana Program. NPs are legally recognized as PCPs and may have hospital privileges. Entry into practice requires a master's degree in nursing and national board certification. The AANP defines NP practice in Oregon as full practice.

The BON regulates prescriptive privileges, defined in OAR 851-055-0070 of the NPA. Oregon allows APRNs with prescriptive privilege to prescribe and dispense drugs within their specialty and competency. Dispensing more than a 72-hour supply requires specific authorization (OAR 851-055-0076). CRNAs are not authorized to dispense medications, and NPs are not authorized to prescribe Death with Dignity medications.

REIMBURSEMENT

NPs are legally entitled to reimbursement by third-party payers. APRNs are recognized as PCPs. Medicaid reimburses NPs for services within their scope of practice at the same rate as physicians. Statutory authority ensures full payment parity from private insurers for NPs in independent practice and when billing through a clinic or practice for primary care and behavioral healthcare.

Pennsylvania

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

PRACTICE AUTHORITY

The Pennsylvania BON grants CRNPs, CNSs, and CRNAs 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, 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 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. The CRNP's SOP is defined in statute and regulation. CRNPs are recognized as PCPs by the Department of Human Services and many insurance companies, but some managed care companies do not recognize them as PCPs. The AANP identifies Pennsylvania's state practice environment for NPs as reduced practice.

The SOP of the CNS, as defined in statute, prohibits the acts of medical diagnosis and prescribing. Act 60 of 2021 defines the term "CRNA" and the CRNA SOP in statute, among other provisions. The CRNA performs their expanded role in cooperation with and under the overall direction of a physician, podiatrist, or dentist.

The Pennsylvania Department of Health authorizes a hospital's governing body to grant and define the scope of clinical privileges to individuals with advice from medical staff. CRNPs must have a master's degree and pass a national certification exam to practice. CRNAs must have a master's degree, a doctoral degree, or a post-master's certificate and must pass a national certification exam to practice. The BOM licenses and regulates CNMs.

The BON confers prescriptive authority, including for Schedules II-V CSs, 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 coursework specific to advanced pharmacology and if the prescribing and dispensing are relevant to the CRNP's area of practice, are documented in a collaborative agreement, are not from a prohibited drug category, and conform with regulations. CRNPs may write a prescription for a Schedule II CS for up to a 30-day supply and may prescribe Schedules III and IV CSs for up to a 90-day supply; Schedule V CS prescribing is not restricted. CRNPs are authorized to request, receive, and dispense pharmaceutical sample medications. Prescriptions must include the CRNP's name, title, and Pennsylvania CRNP certification number.

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 that the nurse or APRN is certified by a state or national nursing organization recognized by the BON. Medicaid reimburses CRNPs and CNMs at 100% of the physician payment for certain services. The Pennsylvania Department of Health allows HMOs to recognize CRNPs as primary care gatekeepers.

Rhode Island

https://health.ri.gov/licensing/nurses
https://npari.enpnetwork.com

PRACTICE AUTHORITY

The Rhode Island BON grants APRNs FPA and regulates their practice. APRNs include those performing CNP, CNS, and CRNA roles. CNMs are licensed and regulated under separate R&R and not regulated by the BON. APRN SOP is defined within the NPA. CNPs are statutorily recognized as PCPs in Rhode Island by the Medicaid managed care program. No law prohibits hospitals from granting admitting and hospital privileges to providers. APRNs are considered licensed independent practitioners. The minimum degree to enter practice for all APRNs is completion of a graduate- or postgraduate-level APRN program; APRNs must also hold national board certification. According to the AANP, NP practice in Rhode Island qualifies as full practice.

APRNs are granted independent prescriptive authority, including authority to prescribe, order, procure, administer, dispense, and furnish OTC drugs, legend drugs, and CSs (R.I. Gen. Laws § 5-34-49) within their APRN role and population focus. Prescribing CSs requires the APRN to register with the Rhode Island BOP, Rhode Island Department of Health, and the DEA.

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. United Healthcare has begun to empanel NPs as PCPs, and Neighborhood Health Plan of Rhode Island fully empanels CNPs as PCPs. The RIte Care program (Rhode Island's Medicaid managed care program) allows CNPs and CNMs to serve as PCPs. CRNAs receive third-party reimbursement for services under the supervision of an anesthesiologist or dentist.

South Carolina

https://llr.sc.gov/nurse
www.scnurses.org/page/APRN

PRACTICE AUTHORITY

The South Carolina BON grants APRNs authority to practice and regulates the practice of NP, CNS, CNM, and CRNA roles. APRNs are subject to the scope and standards of practice established by the BON-approved credentialing organization representing their specialty area of practice. Additionally, APRNs may perform activities of advanced practice consisting of nonmedical acts such as population health management; quality improvement or research projects within a healthcare system; and analysis of data and corresponding system recommendations, revisions, developments, or informatics.

For the performance of medical acts, including prescribing medications, NPs, CNSs, and CNMs practice pursuant to a written practice agreement developed with licensed physicians or medical staff who are readily available in person or by electronic means for consultation. The collaborating physician must be licensed in and practicing within the geographic boundaries of South Carolina. Practice agreement requirements are defined in S.C. Code Ann. Section 40-33-34. A licensed physician may enter into a practice agreement with a maximum of the equivalent of six full-time NPs, CNSs, CNMs, or PAs (a physician may request an exception to this requirement). CNMs may also practice pursuant to written policies and procedures for practice developed with an obstetrics and gynecology physician. CRNAs practice pursuant to approved written guidelines developed with a supervising physician or dentist or by medical staff within the facility where practice privileges have been granted. South Carolina is considered a restricted practice state by the AANP.

APRNs are authorized to admit patients to a hospital and hold hospital privileges at the discretion of the individual agency. APRNs must hold a doctorate, a post-nursing master's certificate, or a minimum of a master's degree in nursing and achieve national certification within 2 years post-graduation.

NPs, CNSs, and CNMs are authorized to prescribe drugs and devices listed in the practice agreement, including Schedules III, IV, and V CSs limited to medical problems within the specialty field of the NP, CNS, or CNM. The practice agreement may include Schedule II nonnarcotic substances, provided that each prescription does not exceed a 30-day supply, and may include Schedule II narcotic substances, provided that the prescription does not exceed a 5-day supply and that another prescription is not written without the written agreement of the physician with whom the NP, CNS, or CNM has entered into a practice agreement. Schedule II narcotic substances for patients in hospice or palliative care or for patients residing in long-term care facilities, if listed in the practice agreement, may be prescribed, provided that the prescription does not exceed a 30-day supply. In addition to required identification, prescriptions must be signed or electronically submitted by the NP, CNM, or CNS with the prescriber's BON-assigned identification number, all prescribing numbers required by law, and the name of the physician where possible. CRNAs are not required to obtain prescriptive authority to deliver anesthesia care (nor can they request prescriptive authority in South Carolina); however, CRNAs must practice pursuant to approved written guidelines with a supervising physician, dentist, or medical staff. APRNs with prescriptive authority may request, receive, and sign for professional samples of medications as included in the practice agreement.

REIMBURSEMENT

All NPs, regardless of specialty, may apply for an NPI number, are reimbursed at 85% of the physician rate, and are recognized as PCPs. According to its October 2024 manual, the state Medicaid program reimburses NPs at 80% of the physician rate. South Carolina requires that NPs have current, accurate, and detailed treatment plans.

South Dakota

www.sdbon.org
https://npasd.enpnetwork.com

PRACTICE AUTHORITY

The South Dakota BON regulates and licenses APRNs. The acronym "APRN" is defined in statute and includes CNP, CNS, CNM, and CRNA roles. SOP is defined in statute, and CNMs and CNPs have FPA. CNMs and CNPs must complete a TTP period of 1,040 practice hours in a CPA with a South Dakota-licensed physician, 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; when the minimum hours are met, the CPA is retired. The AANP designates South Dakota NP practice as full practice.

CRNA practice does not require a CPA or on-site supervision. CNS practice requires physician collaboration before ordering DME or therapeutic devices. A written agreement or on-site supervision is not required. 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.

South Dakota's CNPs, CNMs, and CRNAs are authorized to prescribe legend drugs and Schedules II, III, and IV CSs. CNPs, CNMs, and CRNAs have two CS registration options. They may either seek South Dakota Controlled Substance Registration (granted by separate application to the South Dakota Department of Health) and DEA registration or they may act as an agent of an institution,

using the institution's registration number to prescribe, provide, or administer CSs. CNPs, CNMs, and CRNAs may request and receive prepackaged drug samples which the CNP, CNM, or CRNA is authorized to prescribe and provide them to their patients for conditions they are treating. Each sample drug shall be accompanied by written administration instructions.

Prior to prescribing any CSs listed in South Dakota Codified Law (SDCL) Chapter 34-20B, the CNP, CNM, or CRNA who has CS registration must register with the state's PDMP and meet requirements in Chapter 34-20E, including standards for documentation of patient care. CNSs do not have prescriptive authority; however, CNSs may order and dispense DME and therapeutic devices in collaboration with a physician.

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 and that they are acting within their SOP.

Tennessee

https://www.tn.gov/health/health-program-areas/health-professional-boards/nursing-board.html
https://tnnpa.com

PRACTICE AUTHORITY

The Tennessee BON grants APRNs authority to practice and regulates their practice. APRNs are defined in statute and include CNP ("NP" in regulation), CNS, CNM, and CRNA roles. APRN SOP is not defined separately beyond the APRN certificate of fitness to prescribe; however, each APRN must maintain national certification in the respective role and specialty (if applicable). The AANP considers NP practice in the state of Tennessee to be restricted.

CRNAs and CNMs are defined in hospital licensure rules, which also provide that 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 addressed in other hospital licensure rules. APRNs are required to hold a master's degree or higher in a nursing specialty and national certification to enter practice.

APRNs meeting requirements for prescriptive authority are eligible for a certificate that is designated "with certificate to prescribe." APRNs who prescribe practice pursuant to protocols jointly developed by the APRN and a collaborating physician. Medical Board rules governing the APRN's collaborating physician are jointly adopted by the BOM and BON. On-site supervision is not required. NPs with a BON-issued certificate of fitness to prescribe may prescribe legend drugs and Schedules II-V CSs. An NP with a certificate of fitness to prescribe must file notice with the BON and include a copy of the formulary describing the categories of legend drugs to be prescribed and/or issued by the NP. The collaborating physician and APRN's contact information must be printed on the prescription; however, the APRN may sign the prescription. NPs may request, receive, and issue pharmaceutical samples.

Prescribers are required to check the Controlled Substance Monitoring Database prior to issuing a prescription for CSs as a new episode of treatment and under other specific circumstances. Additionally, statutory limitations and requirements on the number of opioids prescribed and dispensed are in place, limiting opioid prescriptions to no more than a 3-day supply and no more than a total dose of 180 morphine milligram equivalent. This limitation is subject to several exceptions under certain circumstances outlined in Tenn. Code Ann. § 63-1-164. "Nonphysician prescribers" may be authorized to prescribe and dispense buprenorphine products to treat opioid use disorder in patients in recovery or MAT under certain conditions with physician supervision and oversight (Tenn. Code Ann. § 53-11-311).

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, implementation is variable, and APRN leaders are working to ensure that this is being addressed. 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.

Texas

www.bon.texas.gov
www.texasnp.org

PRACTICE AUTHORITY

The Texas BON licenses and regulates APRNs, which include the following roles: CNPs, CNSs, CNMs, and CRNAs. The APRN 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 a healthcare team. Authority to make a medical diagnosis and write prescriptions is delegated by an MD or DO using written protocols or other written

authorization. Protocols are agreed upon and signed by the APRN and delegating physician, reviewed and resigned at least annually, and maintained in the practice setting of the APRN. The AANP considers Texas a restricted practice state.

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 must complete a graduate or postgraduate program accredited by a national accrediting body. CNSs must hold a minimum of a master's degree in nursing. All APRNs must hold national board certification in their role and population focus to practice.

APRNs may be delegated prescriptive authority by a physician through a completed prescriptive authority agreement in accordance with regulatory standards and requirements as defined in §222.5 of Title 22, Part 11 of the Texas Administrative Code. The agreement includes nonprescription drugs, dangerous drugs, and devices, including DME, and may include Schedules III-V CSs. Delegation of authority to prescribe CSs has the following limitations: prescriptions may not exceed a 90-day supply in the form of a new or refill prescription; beyond the initial 90 days, refills for Schedules III-V CSs require consultation with the delegating physician and documentation of the consult; and prescriptions for a child younger than 2 years of age shall not be authorized prior to consultation with the delegating physician and documentation of the consult. Schedule II CS prescribing authority may be delegated to an APRN when prescribing, in a hospital facility-based practice, either to a patient who has been admitted for an intended length of stay of 24 hours or longer or a patient who is receiving services in the ED; it may also be delegated to an APRN when prescribing for a patient receiving hospice care as part of the plan of care for treatment.

APRNs must review the Prescription Monitoring Program prior to writing a prescription for an opiate, benzodiazepine, barbiturate, or carisoprodol (Health and Safety Code §481.0764). APRNs with prescriptive authority may request, receive, possess, and distribute samples of drugs they are authorized to prescribe as defined in §222.9 of Title 22, Part 11 of the Texas Administrative Code.

REIMBURSEMENT

All APRN categories are eligible for direct Medicaid reimbursement at 92% of the physician payment. Under certain circumstances, physicians in the Texas Medicaid program may bill for an APRN's services and receive 100%. Some programs, such as Texas Health Steps, reimburse all providers at the same rate. APRNs may be PCPs in Medicaid and Children's Health Insurance Program managed care networks regardless of whether their collaborating physician is in network. APRNs are listed in the Texas Insurance Code as practitioners who must be reimbursed by indemnity health insurance plans.

Utah

https://dopl.utah.gov/nursing
https://utahnp.enpnetwork.com

PRACTICE AUTHORITY

The Utah BON, in collaboration with the Utah Division of Occupational and Professional Licensing, grants authority to practice via licensure as an "APRN" or "APRN-CRNA without prescriptive practice" and regulates these roles' practice pursuant to Utah Nurse Practice Act, 58-31b-302. Licensed APRN roles include CNP, CNS, CNM, and CRNA. CNMs are regulated by a separate practice act and CNM board. APRN SOP is defined by set standards from national, professional, and specialty organizations, and APRNs practice independently. The AANP considers the practice of NPs in Utah to be full practice. Amendments to Utah Code Section 58-31b-803 in 2023 removed a TTP period for CS II prescribing.

APRNs are not statutorily prohibited from admitting patients and holding hospital privileges; however, this is pursuant to institutional policy. All APRNs must hold a master's degree or higher and hold national board certification to be licensed in Utah.

APRNs, including CNMs, have prescriptive authority for all legend drugs and devices within their defined SOP, including Schedules II-V CSs. CRNAs may order and administer drugs, including Schedules II-V CSs, in a hospital or ambulatory care setting; they may not provide prescriptions to be filled outside the hospital. APRNs, including CNMs and CRNAs, apply for DEA registration after obtaining a state CS license; CRNAs may use facility DEA numbers under certain conditions. APRNs and CNMs may sign for and dispense drug samples.

REIMBURSEMENT

The state insurance code has a nondiscrimination code; nothing prohibits reimbursement. APRNs are reimbursed by most insurance companies. Medicaid empanels and reimburses 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 85% of the physician rate.

Vermont

https://sos.vermont.gov/nursing
www.vtnpa.org

PRACTICE AUTHORITY

The Vermont BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP ("NP" in regulation), CNS in psychiatric/mental health nursing, CNM, and CRNA roles. APRNs are independent providers after a TTP requirement is met (2,400 hours and 2 years for primary credential; 1,600 hours and 1 year for secondary credential) 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 graduate degree in nursing and hold national board certification to enter practice. The AANP considers Vermont a full practice state.

APRNs have full prescriptive authority, including for Schedules II-V CSs, within their SOP. APRNs have the same privileges dispensing and administering drugs as physicians. Prescribers are required to query the Vermont Prescription Monitoring System when prescribing an opioid within Schedules II-IV for the first time for chronic pain; when writing a replacement prescription for a Schedule II, III, or IV CS; when starting a patient on a Schedule II, III, or IV CS for nonpalliative long-term pain therapy of 90 days or more; and in certain other situations (18 V.S.A. § 4289). NPs are authorized to request, receive, and/or dispense pharmaceutical samples.

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. Vermont Medicaid reimbursement is 90% for all APRNs except CRNAs and CNMs, who receive 100% reimbursement by rules. Legislation authorizes reimbursement to APRNs providing telehealth services within and outside of a healthcare facility.

Virginia

www.dhp.virginia.gov/Boards/Nursing/PractitionerResources/AdvancedPracticeRegisteredNurse/
www.vcnp.net

PRACTICE AUTHORITY

The Virginia BON and BOM have joint statutory authority to regulate licensed APRNs. APRNs include NP, CNM, CRNA, and CNS roles. All APRNs who possess prescriptive authority may prescribe devices and Schedules II-VI drugs. According to the definition of the role in §54.1-3000 of the Code of Virginia, APRNs must have completed an advanced graduate-level education program in a specialty category of nursing and passed a national certifying exam for that specialty.

A TTP period of 3 years (5,400 hours) of full-time clinical experience is required where NPs practice in collaboration and consultation with a patient care team physician or NP as part of a patient care team within a written or electronic practice agreement unless they possess the autonomous practice designation on their NP license. NPs may qualify for autonomous practice following attestation of the TTP from a patient care team physician or from an attesting NP who assumed management and leadership of the NP during the TTP pursuant to certain circumstances specified in the law and who has been authorized to practice without a written or electronic practice agreement for at least 3 years (Code of Virginia §54.1-2957). Those NPs with autonomous practice designation must: 1) practice within the scope of their clinical and professional training and limits of their knowledge and experience, consistent with applicable standards of care; 2) consult and collaborate with other healthcare providers based on clinical conditions of the patient; and 3) establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate healthcare providers. The AANP considers NP practice in Virginia to be restricted practice.

Physicians who enter into a practice agreement with an NP may only collaborate at any given time with up to 6 NPs or 10 PMHNPs with prescriptive authority. Periodic review of health records is required, and physician collaboration and consultation may be satisfied via telemedicine. The collaborating physician is not required to practice regularly at the same site as the NP with prescriptive authority.

NP practice is based on education, certification, and a written practice agreement (unless the NP possesses the autonomous practice designation), 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. A master's degree in nursing and national board certification are required to enter practice in Virginia. NPs are also authorized to certify medical necessity of DME for Medicaid reimbursement.

CNMs with fewer than 1,000 hours of clinical experience must practice in consultation with a licensed physician or an "independent practice midwife" (defined as a CNM with 2 or more years of independent practice or a licensed certified midwife with 2 or more years of independent practice) in accordance with a practice agreement. A CNM who has completed 1,000 hours of practice as a CNM may practice without a practice agreement upon receipt of an attestation from the licensed physician or CNM with whom they entered into a practice agreement. CRNAs practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry and possess prescriptive authority to prescribe to a patient requiring anesthesia, as part of the periprocedural care of such patients. CNSs may be granted prescriptive authority upon submission of evidence of qualification to prescribe. Once granted prescriptive authority, the CNS must enter into a practice agreement with a licensed physician.

The joint regulations of the BON and BOM include requirements for continued APRN prescriptive authority competency, including 8 hours of CE in pharmacology or pharmacotherapeutics for each biennium. APRNs with prescriptive authority may receive and dispense drug samples under § 54.1-3301 in the Code of Virginia.

REIMBURSEMENT

The Code of Virginia requires health insurers and health services plan providers whose policies or contracts cover services that may be legally performed by a licensed APRN to provide equal coverage for such services when rendered by an APRN.

Washington

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

PRACTICE AUTHORITY

The Washington BON grants and regulates APRN authority to practice; APRNs, currently titled "ARNPs" in statute, include NP, CNS, CNM, and CRNA roles. Effective June 30, 2027, the title will change to "APRN." ARNP SOP is defined in statute and regulation and is considered independent. ARNPs assume primary responsibility for continuous and comprehensive management of a broad range of patient care, concerns, and problems. The AANP considers NP practice in the state of Washington to be full practice.

ARNPs are legally authorized to serve as PCPs, admit patients to a hospital, and hold hospital privileges. However, hospitals and medical staff have the right to decide whether to credential an ARNP. A graduate degree and national certification are required to obtain licensure as an ARNP in Washington.

All ARNPs who receive prescriptive authority have the option to prescribe legend drugs and Schedules II-V CSs. ARNPs are legally authorized to request, receive, and dispense pharmaceutical samples.

REIMBURSEMENT

Medicaid and Labor & Industries reimbursement is available to ARNPs at 100% of the physician rate. 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. King County Superior Court, however, 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 that of physicians for the same service.

Health plans must reimburse a provider for audio-video and audio-only telehealth visits at the same rate as healthcare services provided in-person.

Washington, D.C.

https://dchealth.dc.gov/bon
https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/nurse_practitioner.pdf
https://npadc.enpnetwork.com/

PRACTICE AUTHORITY

The Washington, D.C. Department of Health Board of Nursing grants FPA to, approves and regulates APRNs. CNPs, CNSs, CNMs, and CRNAs encompass the APRN role. Current law authorizes APRNs to practice independently at the time of licensure/certification without a physician collaborative agreement or protocols. APRN SOP is defined in statute without limitations and includes the ability to recommend the use of medical cannabis to a qualifying patient. APRNs may hold hospital admitting privileges. AANP considers NP practice in Washington, D.C. FPA.

National certification in an APRN role is required to begin practice. Washington, D.C. regulations provide full prescriptive authority, including prescription of Schedules II-V CSs and medication assisted treatment (MAT), and allow dispensing of all medications, including sample medications. Both a valid District of Columbia CS registration and a valid DEA registration are needed to prescribe CSs in Washington, D.C.

REIMBURSEMENT

APRNs receive direct reimbursement for providing substance use disorder, alcohol use disorder, and mental illness care; healthcare plans or institutions are prohibited from discriminating against APRNs with clinical privileges. Private third-party payers reimburse for NP services. APRNs are statutorily recognized as PCPs. NPs and CNMs receive Medicaid payment as PCPs.

West Virginia

https://wvrnboard.wv.gov/
https://wvnurses.nursingnetwork.com/

PRACTICE AUTHORITY

The West Virginia RN Board grants authority to practice and regulates the practice of APRNs. The term APRN is defined in statute and regulation and includes the 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. CRNAs administer anesthesia in cooperation (as defined) with a physician, dentist, or podiatrist. CRNAs do not have independent practice authority. The AANP considers NP practice in the state of West Virginia to be reduced.

APRNs are defined in regulation as primary healthcare professionals. 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 practice in West Virginia.

Qualified APRNs have autonomous prescriptive authority following 3 years of a duly documented collaborative relationship with a physician as well as application to and approval for prescriptive authority without a collaborative agreement by the Board.

Prescriptive authority includes Schedules II, III, IV, and V CSs. Drugs listed as Schedule II CSs are limited to a 3-day supply. R&R 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.

Upon initially prescribing or dispensing any Schedule II CS, any opioid, or any benzodiazepine, as well as at least annually thereafter if continuing to treat the patient with a CS, the APRN must access the West Virginia Controlled Substances Monitoring Program for information regarding the patient and document the information. APRNs are authorized to sign for and provide drug samples.

REIMBURSEMENT

FNPs, PNPs, gerontological NPs, adult NPs, WHNPs, and PMHNPs 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, R&R have not been promulgated. NPs and CNMs are defined as PCPs: 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 Health Care Act provides for direct access, at least annually, to a women's healthcare provider for a well-woman exam. Providers include APRNs, CNPs, CNMs, FNPs, WHNPs, adult NPs, gerontological NPs, and PNPs.

Wisconsin

https://dsps.wi.gov/pages/Professions/Default.aspx
https://wisconsinanp.enpnetwork.com

PRACTICE AUTHORITY

The Wisconsin BON regulates the practice of Advanced Practice Nurses (APNs), including CNP (NP in statute), CNS, CNM, and CRNA roles. SOP is not defined in statute for NPs, CNSs, or CRNAs, except for reference to prescriptive authority (Wisconsin Administrative Code [WAC] § N 8.10); however, SOP is defined in statute and rules for CNMs (Wisconsin Stat. § 441.15(1)(b) and WAC § N 4.06. An APN must have a master's or doctoral degree in nursing or a related field and national board certification to practice if licensed after 1998. Until September 1, 2026, Wisconsin requires all APNs to practice in a collaborative relationship with a physician. The AANP considers NP practice in Wisconsin to be reduced practice until September 1, 2026.

APRNs with more than 3,840 hours of professional nursing experience in a clinical setting, during which at least 24 months have elapsed since the APRN first began the required hours, and completion of an additional 3,840 hours of APRN practice over at least 24 months in their recognized role working with a physician or dentist as defined, may qualify for independent practice after September 1, 2026.

2025 Wisconsin Act 17 creates a new system of licensure that allows an RN to be licensed by the BON as an APRN. Among other things, the act creates requirements to allow an APRN to issue prescription orders, use the title APRN, and delegate certain tasks to other clinically trained health care workers. The act recognizes four APRN roles including CNM, CRNA, CNS, and NP.

REIMBURSEMENT

Specified, reimbursable billing codes are reimbursed by Medicaid at 100% for 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. CHAMPUS reimburses NPs, and home health RNs bill under their own provider number.

Wyoming

https://wsbn.wyo.gov
https://wcapn.enpnetwork.com

PRACTICE AUTHORITY

The Wyoming BON grants APRNs the authority to practice via licensure and regulates their practice. APRN is defined in the Wyoming Statutes Annotated § 33-21-120 and SOP is further described in Wyoming Administrative Rules, Chapter 3, Section 3(a), reflecting the standards and SOP established by national professional associations and/or accrediting agencies representing the core, role, and population focus areas for APRNs. The AANP considers NP practice in Wyoming to be full practice.

APRNs are statutorily defined as PCPs and may be permitted to admit patients to a hospital and hold hospital privileges. A doctorate or master's degree in nursing in a specific APRN role and national board certification in that role are required to enter practice.

BON-approved APRNs may independently prescribe, order, procure, administer, dispense, and furnish OTC, legend, and CSs within their role and population focus. APRNs with prescriptive authority are legally authorized to request, receive, and dispense pharmaceutical samples.

REIMBURSEMENT

APRNs are authorized to receive Medicaid payments at 85% of the physician rate. All PCPs may receive third-party payment; however, policies differ among third-party payers.