Analysis of SB 1063, PN 1341
Providing Full Practice Authority
for Certified Nurse Practitioners

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The proposed legislation would modernize The Professional Nursing Law to allow nurse practitioners to practice as licensed independent practitioners within the particular clinical specialty area or population focus in which they hold current certification from a national certification program that required the passing of a national certifying examination.

The legislation is intended to align Pennsylvania’s regulation of nurse practitioners with the standards set forth in the Model Nursing Practice Act developed by the National Council of State Boards of Nursing. Enactment would put the Commonwealth’s nurse practitioners on a par with nurse practitioners in 17 other states and the District of Columbia.

Set forth hereinafter is an analysis of the specific provisions of the legislation.1

Independent Practice

As described more fully under “Scope of Practice,” the proposed legislation would make only modest changes in the functions nurse practitioners are authorized to perform under current law. However, the legislation would eliminate the current requirement that nurse practitioners perform those functions only pursuant to a collaborative agreement with a physician.2 As a result, a nurse practitioner would be entitled to practice as a licensed independent practitioner, but the nurse practitioner would be limited to doing so only within the scope of practice of the particular clinical specialty area or population focus in which the nurse practitioner has passed a national certifying examination recognized by the State Board of Nursing.3

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1 The proposed legislation amends the act of May 22, 1951 (P.L. 317, No. 69), known as “The Professional Nursing Law.” Unless designated as “proposed,” the sections of The Professional Nursing Law cited in the following footnotes are as they appear in the current law.

2 Proposed Section 2(13) [repealer], proposed Section 8.2(b) and (c.1), and proposed Section 8.3(a)(2)

3 Proposed Section 2(16) and (21); proposed Section 8.2(a)(1), (b), and (c.1); and proposed Section 8.3(a)(2) and (b)
Nurse practitioners collaborate every day with a variety of other health care providers, including physicians; eliminating the collaborative agreement would not change that fact. Furthermore, as under current law, a nurse practitioner would be authorized to perform acts of medical diagnosis and to prescribe and dispense drugs only in accordance with Nursing Board regulations.\(^4\)

Notwithstanding that the proposed legislation would grant nurse practitioners the legal right to practice independently, the legislation would also permit an individual nurse practitioner to practice pursuant to a collaborative agreement if that nurse practitioner opted to do so.\(^5\)

**Scope of Practice**

Under current law, a certified registered nurse practitioner ("CRNP") is required to practice within the scope of practice of the particular clinical specialty area in which the nurse has been certified by the Nursing Board.\(^6\) In 2002, the General Assembly amended the then-existing practice authority to authorize CRNPs to prescribe and dispense drugs.\(^7\) Subsequently, in 2007, the General Assembly added a list of enumerated functions to the practice authority of CRNPs as it existed after the 2002 amendments.\(^8\)

The proposed legislation would retain the scope of practice as it existed after the 2002 amendments and as it was expanded by the 2007 amendments. The legislation would also make the following modest changes in the list of enumerated functions that were added in 2007:

- Eliminate the requirement that any oral orders issued by a nurse practitioner be expressly permitted by a health care facility. This change would allow a nurse practitioner to issue an oral order in a health care facility unless that facility expressly prohibited a nurse practitioner from issuing such an order.\(^9\)

- Authorize a nurse practitioner to make referrals for speech therapy. The enumerated list of functions added in 2007 expressly authorized a nurse practitioner to make referrals for physical therapy, respiratory therapy, and occupational therapy.\(^10\)

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\(^4\) Section 2(1) and Section 8.2(c), proposed Section 8.2(b), and proposed Section 8.3(b)

\(^5\) Although proposed Section 8.2(a)(1) would “entitle” a nurse practitioner to practice independently, the language would not “require” a nurse practitioner to do so.

\(^6\) Section 8.2(a)

\(^7\) Section 8.3

\(^8\) Section 8.2(c.1)

\(^9\) Proposed Section 8.2(c.1)(3)

\(^10\) Section 8.2(c.1)(4) and proposed Section 8.2(c.1)(5)
- Authorize a nurse practitioner to order methadone treatment. Under existing law, a nurse practitioner may perform and sign the initial assessment of methadone treatment evaluations, but only a physician may order methadone treatment.\textsuperscript{11}

- Eliminate inconsistencies in the current law relating to referrals by a nurse practitioner to a dietitian. The enumerated list of functions added in 2007 explicitly states that a nurse practitioner may make such referrals.\textsuperscript{12} However, the provision of current law related to third-party reimbursement of a licensed dietitian-nutritionist explicitly recognizes referrals from physicians, dentists, and podiatrists but does not explicitly recognize referrals from nurse practitioners. Furthermore, the definition of “medical nutrition therapy” in the current law does not include orders by nurse practitioners. The proposed legislation would eliminate these inconsistencies by adding nurse practitioner referrals to the provision of current law related to third-party reimbursement of licensed dietitian-nutritionists and by including orders by nurse practitioners in the definition of “medical nutrition therapy.”\textsuperscript{13}

**Prescriptive Authority**

Because of the 2002 amendments, a nurse practitioner is permitted to prescribe and dispense drugs if the nurse meets specified education requirements, is acting in accordance with Nursing Board regulations, and has a written collaborative agreement with a physician. As described more fully under “Independent Practice,” the proposed legislation would eliminate the mandatory collaborative agreement. However, the legislation would make no change in the education requirements and would retain the Nursing Board’s regulatory responsibilities and authority.\textsuperscript{14}

The 2002 amendments established a Drug Review Committee, composed of nurse practitioners, physicians, and pharmacists and chaired by the Secretary of Health, the Physician General, or a designee. Approval by the Drug Review Committee is required before the Nursing Board may add or delete any category of drugs nurse practitioners are permitted to prescribe.\textsuperscript{15}

The proposed legislation would eliminate the Drug Review Committee. In place of the role now filled by that committee, the legislation would expressly authorize a nurse practitioner to prescribe and dispense proprietary and non-proprietary drugs, subject to any restrictions imposed by Nursing Board regulations or by federal law. In addition, the legislation would add

\textsuperscript{11} Proposed Section 8.2(c.1)(8)  
\textsuperscript{12} Section 8.2(c.1)(4)  
\textsuperscript{13} Proposed Section 2(10) and proposed Section 3.1  
\textsuperscript{14} Proposed Section 8.3(a)  
\textsuperscript{15} Section 8.3(b) and Section 8.4
definitions of “proprietary drug,” “non-proprietary drug,” and “controlled substance” that are substantially the same as the definitions of those terms in the Pharmacy Act.\textsuperscript{16}

“Certified” v. “Licensed”

Under current law, a nurse practitioner must be licensed by the Nursing Board as a registered nurse and also certified by the Nursing Board as a CRNP. To be certified as a CRNP, a nurse must have fulfilled specified education requirements and must hold current certification from a Nursing Board-recognized national certification organization. To be recognized by the Nursing Board, that national certification organization must have required the nurse to pass a national certifying examination in the particular clinical specialty area in which the nurse is seeking certification by the Board.\textsuperscript{17}

The proposed legislation would make no change in the education requirement and would retain the requirement that the nurse hold certification from a Board-recognized national certification program which required passing a national certifying examination. However, the legislation would provide that a qualified nurse be \textit{certified} by the national program but be \textit{licensed} (rather than certified) by the Nursing Board.\textsuperscript{18} As a result, a nurse practitioner would hold both a license issued by the Nursing Board as a registered nurse and a license issued by the Nursing Board as a certified nurse practitioner. Henceforth, the term “certification” would refer only to the status conferred by the national program. As under current law, no statutory language would prohibit a nurse from ceasing practice as a nurse practitioner and practicing thereafter only within the more limited scope applicable to a licensed registered nurse.

To simplify administration, a nurse practitioner’s license would expire on the same date as that nurse practitioner’s license as a registered nurse.\textsuperscript{19}

The proposed legislation contains no “grandparenting” clause because such a clause would be unnecessary. Specifically, until the effective date of the legislation, nurse practitioners would continue to be certified by the Nursing Board as CRNPs.\textsuperscript{20} Immediately upon the legislation’s becoming effective, all existing CRNPs would automatically be deemed to be licensed, rather than certified, by the Board.\textsuperscript{21} Thereafter, new nurse practitioners entering the

\textsuperscript{16} Proposed Section 2(14) [repealer], (18), (19), and (20); proposed Section 8.3 (b); and proposed Section 8.4 [repealer]

\textsuperscript{17} Section 2(12) and Section 8.1(a), (b), and (c)

\textsuperscript{18} Proposed Section 8.8(a), (b), and (c)(3). The substantive education and national certification requirements in proposed Section 8.8(a), (b), and (c)(3) are the same as the substantive education and national certification requirements in Section 7(b) and Section 8.1(a), (b), and (c) of the current law.

\textsuperscript{19} Proposed Section 8.8(c)(1) and (2)

\textsuperscript{20} Proposed Section 8.1(d)

\textsuperscript{21} Proposed Section 8.8(a)
profession would be licensed by the Board rather than certified.\textsuperscript{22} Similarly, qualified out-of-state practitioners would henceforth be licensed rather than certified by the Nursing Board.\textsuperscript{23} This approach to handling the transition would be appropriate because the required qualifications would not change; only the “piece of paper” issued by the Nursing Board would change (\textit{i.e.}, from a state certificate to a state license).

**Title**

Under current law, a qualified nurse practitioner holds the title of “certified registered nurse practitioner.”\textsuperscript{24} Consistent with the transition from state certification to state licensure, the proposed legislation would confer the title of “advanced practice registered nurse-certified nurse practitioner” and the letters “A.P.R.N.-C.N.P.” \textsuperscript{25} It would be unlawful for any person to use the title “advanced practice registered nurse-certified nurse practitioner” or the letters “A.P.R.N.-C.N.P” unless that person is actually licensed by the Nursing Board as a certified nurse practitioner.\textsuperscript{25}

To avoid any ambiguity, the proposed legislation would also specify that the terms “certified registered nurse practitioner,” “registered nurse practitioner,” “certified nurse practitioner,” or “nurse practitioner” in any other statute shall be deemed to include a person licensed by the Nursing Board as a “certified nurse practitioner.”\textsuperscript{26}

**“Clinical Specialty Area” v. “Population Focus”**

Under current law, a nurse practitioner must pass a national certifying examination in a particular “clinical specialty area” and must practice solely within that clinical specialty area.\textsuperscript{27} In recognition of an evolution in nurse practitioner education and certification programs, the proposed legislation would provide for certification in a particular “population focus” rather than in a particular clinical specialty area.\textsuperscript{28}

The proposed legislation would define “population focus” as a category of the population within which the nurse practitioner practices. The legislation would designate six specific

\textsuperscript{22}Proposed Section 8.8(b)

\textsuperscript{23}Proposed Section 7(b)

\textsuperscript{24}Section 2(12) and Section 8.1(a)

\textsuperscript{25}Proposed Section 8.8(e)(2)

\textsuperscript{26}Proposed Section 8.8(e)(1). In addition, throughout the bill, there are amendments to the current law that would replace “certified registered nurse practitioner” with “certified nurse practitioner.”

\textsuperscript{27}Section 8.1(b)(1)(ii) and Section 8.2(a)

\textsuperscript{28}Proposed Section 8.2(a)(1) and proposed Section 8.8(a) and (b)(3)
categories but would authorize the Nursing Board to designate additional categories as education and national certification programs evolve. The legislatively-designated categories would be family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women’s health/gender-related, and psychiatric/mental health.29

There are currently 27 clinical specialty areas but only six population foci in which nurse practitioners may be certified. In effect, each of the 27 clinical specialty areas is a subset of one of the six population foci. A nurse practitioner who is certified in one clinical specialty area may, or may not, be qualified in the other clinical specialty areas subsumed under the same population focus. Therefore, the proposed legislation would provide for a transition.

Specifically, a nurse practitioner who, on the legislation’s effective date, is certified by the Nursing Board to practice only in a particular clinical specialty area (or areas), would immediately be licensed to practice in only that area (or those areas).30 In contrast, a nurse practitioner who, on that date, is certified by the Nursing Board in a clinical specialty area but who holds the requisite national certification in a population focus would immediately be licensed to practice within that population focus.31

Similarly, a nurse practitioner obtaining an initial license from the Nursing Board on or after the legislation’s effective date could practice within a population focus immediately upon licensure if, at the time of licensure, that nurse practitioner holds current certification from a Board-recognized national certification program that requires passing a national certifying examination in that population focus.32

The Nursing Board would be required to establish a procedure to authorize a nurse practitioner to practice in an additional clinical specialty area or in an entire population focus if, following the legislation’s effective date, that nurse practitioner obtains current certification from a Board-recognized national certification program that requires passing a national certifying examination in that additional clinical specialty area or in the entire population focus.33

Under the legislation, the Nursing Board could license a nurse practitioner to practice within more than one population focus, provided that the nurse practitioner holds current certification from a Board-recognized national certification program that required passing a national certifying examination in each population focus within which the nurse practitioner is seeking to be licensed.34

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29 Proposed Section 2(17)
30 Proposed Section 8.2(a) and proposed Section 8.8(a)
31 Proposed Section 8.2(a) and proposed Section 8.8(a)
32 Proposed Section 8.2(a) and proposed Section 8.8(b)
33 Proposed Section 8.8(d)
34 Proposed Section 8.2(a) and proposed Section 8.8(a) and (b)
Medical Staff Membership and Clinical Privileges

Current law expressly provides that nothing in the scope of practice section of The Professional Nursing Law shall be construed (i) to supersede the authority of the Department of Health and the Department of Public Welfare to regulate the types of health care professionals who are eligible for medical staff membership or clinical privileges or (ii) to restrict a health care facility’s authority to determine the scope of practice and the supervision or other oversight requirements for health care professionals practicing within that facility.35 Consistent with recognizing nurse practitioners as licensed independent practitioners, the proposed legislation would repeal both of these provisions.36

This repeal would not automatically override any state regulations that exclude nurse practitioners from medical staff membership or clinical staff privileges. Similarly, the repeal would not automatically supersede the authority of any health care facility regarding scope of practice, supervision, or oversight. However, the repeal would put the Department of Health, the Department of Public Welfare, and individual health care facilities on notice that the General Assembly has determined that nurse practitioners licensed by the Nursing Board are qualified and entitled to practice independently and that those departments and facilities should consider changes in their current requirements.

Payment for Services

Under current law, the payment for a service provided by a nurse practitioner is part of the payment made by a health care plan, an insurer, or another third-party payor to the physician with whom the nurse practitioner has a collaborative agreement or to the health care facility by which the nurse practitioner is employed. The physician or the health care facility is responsible for compensating the nurse practitioner.

Consistent with authorizing a nurse practitioner to practice as a licensed independent practitioner, the proposed legislation would provide for direct reimbursement of the nurse practitioner for services provided. Specifically, if a nurse practitioner otherwise satisfies the plan’s requirements, the nurse practitioner would be entitled to be recognized as a primary care provider under a managed care or other health care plan. Similarly, a nurse practitioner who otherwise satisfies the requirements of the insurer or other third-party payor would be entitled to be reimbursed directly by that insurer or other payor.37

Professional Corporations

35 Section 8.2(c.2)
36 Proposed Section 8.2(c.2)
37 Proposed Section 8.2(a)
Under Title 15 of the Pennsylvania Consolidated Statutes, a nurse practitioner may form a professional corporation with other registered nurses. A nurse practitioner may also form a professional corporation with any other health care practitioners who treat human ailments and conditions and who are licensed to provide health care services in Pennsylvania without receiving a referral or supervision from another health care practitioner. However, any health care practitioner is entitled to form a professional corporation with another category of health care practitioner only if the state licensing board of each of the affected health care practitioners has promulgated a regulation authorizing such a combined practice.

To date, the Nursing Board and the State Board of Medicine have promulgated regulations authorizing professional corporations of individuals from different health care professions. The State Board of Osteopathic Medicine has not yet promulgated the necessary regulation. To remove any doubt about the applicability of the State Board of Medicine’s regulation to nurse practitioners and to fill the void left by the State Board of Osteopathic Medicine, the proposed legislation would expressly authorize a nurse practitioner to form a professional corporation with other registered nurses and with both medical doctors and doctors of osteopathic medicine.

**Regulations**

The amendments made by the proposed legislation to The Professional Nursing Law would be self-executing. In other words, they would take effect on the effective date of the legislation and would automatically supersede any conflicting or inconsistent Nursing Board regulations. However, to eliminate potential confusion, the proposed legislation would require the Nursing Board to promulgate any new regulations and any amendments to existing regulations needed to make the Board’s regulations consistent with the legislation. The Nursing Board would be required to initiate the promulgation within 90 days of the legislation’s effective date.

**Effective Date**

The proposed legislation would take effect 60 days following enactment.

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38 15 Pa. C.S. §§2903(d)(1) and 2925

39 15 Pa. C.S. §2903(d)(1)(ii)

40 49 Pa. Code §§ 21.6 and 16.21, respectively

41 Proposed Section 8.8(f)

42 Section 9 of the proposed legislation

43 Section 10 of the proposed legislation