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Senate Bill 2 (Substitute S-1 as passed by the Senate)
Sponsor: Senator Mark C. Jansen
Committee: Reforms, Restructuring and Reinventing

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RATIONALE

In Michigan, the Public Health Code provides for the certification of registered professional nurses (R.N.s) who have advanced training beyond that required for a license, and have demonstrated competency through examination or evaluation, as a nurse midwife, nurse practitioner, or nurse anesthetist. Certified R.N.s must practice under the supervision of a licensed physician and, depending on the R.N.'s certification, a licensed physician may delegate certain authority to an R.N.

Advanced practice registered nurses (A.P.R.N.s) are not recognized by the Code. In states that recognize A.P.R.N.s, the title typically encompasses licensed, or certified, nurse midwives, anesthetists, practitioners, and specialists. Michigan is one of 21 states that do not recognize A.P.R.N.s. In 16 states and Washington, D.C., A.P.R.N.s are allowed to practice autonomously with regard to providing diagnosis and treatment, and are allowed to write prescriptions independently. Generally, A.P.R.N. models vary based on the type of license or certification, and the degree to which an A.P.R.N. may practice autonomously or prescribe drugs independently.

Many people believe that the use of A.P.R.N.s can improve the quality and accessibility of health care, and will help address the shortage of medical professionals that currently exists and is expected to grow. Because Michigan law does not recognize A.P.R.N.s, however, and the scope of their practice elsewhere is broader than the scope of practice of R.N.s with advance practice credentials in this State, there is concern that these R.N.s are leaving Michigan or deciding not to locate in this State. Therefore, it has been suggested that the Code should provide for, set regulatory standards for, and define the scope of practice for A.P.R.N.s, and allow A.P.R.N.s independence to practice, and prescribe drugs, within the context of their education, training, national certification, and scope of practice.

CONTENT

The bill would amend Part 172 (Nursing) of the Public Health Code to provide for the licensure of advanced practice registered nurses, who would include certified nurse midwives, certified nurse practitioners, and clinical nurse specialist-certifieds; and eliminate provisions regarding the specialty certification of nurse midwives and nurse practitioners. The bill also would do the following:

- **Prescribe A.P.R.N. license fees, and a method for review and adjustment.**
- **Authorize a licensed A.P.R.N. to prescribe and administer nonscheduled prescription drugs and Schedule 2 through 5 controlled substances if he or she met certain criteria.**
- **Require an A.P.R.N. to enter into a mentorship agreement if he or she had been licensed or certified for less than four years.**
- **Allow an A.P.R.N. to issue a complementary starter dose of a prescription drug or Schedule 2 to 5 controlled substance.**

- **Create the A.P.R.N. Task Force.**
- **Revise the membership of the Michigan Board of Nursing.**
- **Allow the Board of Nursing to require a licensee under Part 172 (Nursing) to provide evidence of the completion of continuing education or competency courses, for license renewal.**

In addition, the bill would amend the Code to include a licensed A.P.R.N. among the individuals who may refer a patient for speech-language pathology services or occupational therapy, and among those who may prescribe physical therapy.

Definitions & Titles

The bill would define "advanced practice registered nurse" or "A.P.R.N." as an individual who is licensed under Part 172 as a certified nurse midwife, certified nurse practitioner, or clinical nurse specialist-certified.

"Certified nurse midwife" or "C.N.M.", "certified nurse practitioner" or "C.N.P.", and "clinical nurse specialist-certified" or "C.N.S.-C" all would mean an individual who is licensed under Part 172 as a registered professional nurse; is also licensed as an A.P.R.N., and meets the requirements applicable to that license; and has a particular focus in his or her practice, as described below.

A certified nurse midwife would, within the parameters of his or her education, training, and national certification, focus on health care services for women throughout their lifespan, including comprehensive maternity care that includes prenatal care, childbirth in diverse settings, postpartum care, and care for newborns who are 28 days old or younger; gynecological, reproductive, and contraceptive care; physical exams; diagnosis and treatment of common health problems with consultation or referral as indicated; the prescription of pharmacological and nonpharmacological interventions and treatments; and treatment of male partners for sexually transmitted infection and reproductive health.

A certified nurse practitioner would, within the parameters of his or her education, training, and national certification, focus on performing comprehensive assessments; providing physical examinations and other health assessments and screening activities; and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. Nursing care provided by a C.N.P. would include ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing pharmacological and nonpharmacological interventions and treatments within the C.N.P.'s specialty role and scope of practice; health promotion; disease prevention; health education; and counseling of patients and families with potential, acute, and chronic health disorders.

A clinical nurse specialist-certified would, within the parameters of his or her education, training and national certification, focus on continuous improvement of patient outcomes and nursing care with broad focus across the areas of direct patient care, patient education, nursing education, nursing practice, and organizational systems. A C.N.S.-C would be responsible and accountable for diagnosis, intervention, and treatment of health or illness states, and disease management, including the use and prescription of pharmacological and nonpharmacological intervention and treatment within his or her specialty and scope of practice; health promotion; and prevention of illness and risk behavior among individuals, families, groups, and communities. In addition, a C.N.S.-C would evaluate patient outcomes; translate evidence into practice; and develop, plan, coordinate, and direct programs of care for acute and chronically ill patients and their families.

The following words, titles, and letters could be used only by those authorized under Part 172 to use them and in a way prescribed in Part 172: "certified nurse midwife", "C.N.M.", "certified nurse practitioner", "C.N.P.", "clinical nurse specialist-certified", and "C.N.S.-C".

A.P.R.N. Duties & Licensure

The bill would require an A.P.R.N. to do the following:

- Provide those functions common to the population for which A.P.R.N.s are educationally and experientially prepared.
- Comply with the standards established by the Board of Nursing and with the national accreditation standards of the national professional nursing associations applicable to his or her license.
- Consult with or refer patients to other health professionals as appropriate, or refer a patient to other health professionals if the care were outside the A.P.R.N.'s education, training, and national certification.
- Supervise R.N.s, licensed practical nurses, and other health professionals as appropriate.

The bill would prohibit a person from engaging in the practice of A.P.R.N. unless licensed or otherwise authorized by Article 15 (Occupations) of the Code.

The bill would require the Board of Nursing to issue an A.P.R.N. license to an R.N. who held a specialty certification, issued by the Board, as a nurse midwife, nurse practitioner, or clinical nurse specialist, if he or she met both of the following requirements:

- He or she applied for an A.P.R.N. license within two years after the bill's effective date.
- His or her license and specialty certification issued by the Board were current on the bill's effective date and on the date he or she submitted the license application.

The Department of Licensing and Regulatory Affairs (LARA) would have to renew an A.P.R.N. license concurrently with the R.N. license.

C.N.M./C.N.P./C.N.S.-C Licensure

The Board of Nursing would be required to issue a certified nurse midwife license, a certified nurse practitioner license, or a clinical nurse specialist-certified license to an R.N. who met all of the following:

- He or she had completed an accredited graduate, postgraduate, or doctoral level nursing education program that prepared the nurse for the role of C.N.M, C.N.P, or C.N.S.-C., as applicable.
- He or she was certified by a nationally accredited certification body as demonstrating role and population focused competencies for C.N.M.s, C.N.P.s, or C.N.S.-Cs, as applicable, or the Board determined that he or she met the standards for that certification.
- He or she maintained continued competence by obtaining recertification in the role and population described above through the national certification program, or the Board determined that he or she met the standards for that recertification.

The person also would have to demonstrate to the Board's satisfaction that he or she met all of the following:

- He or she had acquired advanced clinical knowledge and skills that primarily prepared him or her to provide direct care to patients, and to provide indirect care.
- His or her practice built on the competencies of R.N.s by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy.
- He or she had clinical experience of sufficient depth and breadth to perform as a licensee.

In addition, the person would have to demonstrate that he or she was educationally prepared to assume responsibility and accountability for health promotion or maintenance and the assessment, diagnosis, and management of patient problems, including the use and prescription of pharmacologic and nonpharmacologic interventions within the parameters of his or her education, training, and national certification.

Specialty Certification

Under Part 172, the Board of Nursing may issue a specialty certification to an R.N. who has advanced training beyond that required for initial licensure and who has demonstrated competency through examination and other evaluative processes and who practices in one of the following specialty fields: nurse midwifery, nurse anesthetist, or nurse practitioner. Beginning on the bill's effective date, this provision would apply only to the specialty field of nurse anesthetist.

Criteria for Practice

In order to engage in the practice of advanced practice registered nursing, an A.P.R.N. would have to meet any of the criteria described below.

For at least four years, the individual had held a national certification as a nurse midwife, nurse practitioner, or clinical nurse specialist-certified; a specialty certification in the practice of nurse midwifery or nurse practitioner before the bill's effective date; or an A.P.R.N. license issued under Part 172. He or she would have to provide written documentation of that certification or licensure to the Board.

If the individual did not meet any of those four-year certification or licensure requirements, he or she had engaged in the practice of advanced practice registered nursing and, if applicable, possessed, prescribed, or administered nonscheduled prescription and Schedule 2 to 5 controlled substances within the parameters of his or her education, and national certification under the terms of one or more mentorship agreements for a total of four years.

If the individual did not meet any of the requirements described above, he or she only engaged in the practice of advanced practice registered nursing and, if applicable, possessed, prescribed, or administered nonscheduled prescription drugs and Schedule 2 to 5 controlled substances within the parameters of his or her education, training, and national certification under the terms of a mentorship agreement and in collaboration with a physician or, if applicable, a dispensing prescriber.

Pharmacy Practice & Drug Control

The bill would authorize a licensed A.P.R.N. to possess, prescribe, and administer nonscheduled prescription drugs and controlled substances included in Schedules 2 through 5, within the parameters of his or her education, training, and national certification, if he or she met all of the following:

- He or she had completed graduate level pharmacology, pathophysiology, and physical assessment courses and clinical practicum in the role of a C.N.M, C.N.P., or C.N.S.-C., as applicable to his or her A.P.R.N. license.
- He or she had completed the number of contact hours in pharmacology as part of the requisite continuing education for a controlled substances license, and for renewal of his or her license under Part 172.
- He or she held a controlled substances license under the Code.
- He or she met the mentorship agreement requirements (applicable to an individual who had not been certified or licensed for four years) to possess, prescribe, or administer those drugs or substances.
- He or she possessed, prescribed, or administered the drug or controlled substance only while engaged in the practice of advanced practice registered nursing within the parameters of his or her education, training, and national certification.

A mentorship agreement would have to be between an A.P.R.N. and a licensed physician who, if applicable, held a controlled substance license, or between the A.P.R.N. and another A.P.R.N. who held the same license under Part 172, had at least five years of work experience in that licensed profession, and, if applicable, held a controlled substances license. The agreement would have to concern engaging in the practice of advanced practice registered nursing and, if applicable, the possession, prescription, and administration of nonscheduled prescription drugs

and Schedule 2 to 5 controlled substances by the A.P.R.N. The agreement also would have to meet the following:

- Include the responsibilities and duties of each party to the agreement.
- Be for a term of one year and be renewable by the parties for one or more additional one-year periods.
- Be revocable by either party, with at least 30 days' written notice.
- Be signed by each party.
- Be in writing.

A person who held an A.P.R.N. license for less than four years could be a party to more than one mentorship agreement.

Before prescribing a controlled substance included in Schedules 2 to 5, the A.P.R.N. would have to request that the Department of Community Health (DCH) provide any data in its electronic monitoring system concerning that controlled substance. He or she would have to consider the data to determine whether prescribing or administering the controlled substance to the intended individual was consistent with patient safety and that it would not likely be subject to abuse by the individual. After prescribing the controlled substance, the A.P.R.N. would have to give the DCH any information about the prescription that a dispensing prescriber is required to report for the electronic monitoring system.

The Department of Licensing and Regulatory Affairs would have to issue a controlled substance license to an A.P.R.N. who applied and was qualified to possess, prescribe, and administer nonscheduled prescription drugs and controlled substances included in Schedules 2 to 5. The Department could place a limitation on the license to reflect the terms of a mentorship agreement.

An A.P.R.N. engaged in the practice of advanced practice registered nursing could, within the parameters of his or her education, training, and national certification, order, receive, and dispense a complementary starter dose of a prescription drug or controlled substance in Schedules 2 to 5 without delegation from a supervising physician. Only the name of the A.P.R.N. would have to be used, recorded, or otherwise indicated in connection with that order, receipt, or dispensing. As required of a prescriber who dispenses complementary starter doses, an A.P.R.N. would have to give certain information to the patient.

The bill provides that it would not require new or additional third-party reimbursement or mandated worker's compensation benefits for services rendered by an A.P.R.N. authorized to prescribe nonscheduled prescription drugs and controlled substances included in Schedules 2 to 5.

Standard of Practice or Care

The bill specifies that, in an action for malpractice or licensure removal, if an A.P.R.N. practiced as an advanced practice registered nurse without the supervision of a physician, he or she would be held to the higher standard of acceptable professional practice or care in the community for a physician as if a physician had acted or failed to take the action that the A.P.R.N. was alleged to have taken or failed to take.

Prohibited Participation in PC or PLLC

As a condition of licensure under Part 172, a A.P.R.N. would be prohibited from organizing or being a shareholder or member of a professional corporation (PC) or professional limited liability corporation (PLLC) after the bill's effective date. An A.P.R.N. who did so would be in violation of a general duty of Article 15 (i.e., it would be grounds for a disciplinary subcommittee to impose sanctions).

In addition to other requirements for issuing a license, LARA would have to include on a form used for a new or renewal license a space for an A.P.R.N. to certify that he or she did not organize or become a shareholder or member of a PC or PLLC after the bill's effective date.

A.P.R.N. Task Force

The bill would create the A.P.R.N. Task Force. The Task Force would have to consist of the following 13 members, who would have to be members of the Board:

- One registered professional nurse.
- Two certified nurse midwives.
- Two certified nurse practitioners.
- Two clinical nurse specialists-certified.
- Two certified nurse anesthetists.
- Two physician members.
- Two public members.

In consultation with LARA, the Task Force would have to develop and make public guidelines on the appropriate scope of practice of an A.P.R.N. according to his or her education, training, and experience. These guidelines would be nonbinding and advisory, and would only express the Task Force's criteria for determining whether an A.P.R.N. was practicing within his or her scope of practice.

The Task Force also would have to do the following:

- In consultation with LARA, serve as the disciplinary subcommittee for A.P.R.N.s and certified nurse anesthetists.
- Make written recommendations to the Board on reinstatement of A.P.R.N. licenses and notices of intent to deny them.
- File an annual report with the Board and LARA concerning any matters prescribed by the Task Force and Board.

Currently, if a health profession specialty field task force is created for a health profession, that task force must serve as the task force for all health profession specialty fields within the scope of practice of the health profession. This requirement would not apply to the A.P.R.N. Task Force. The Task Force also would not be subject to requirements that a task force make recommendations to a licensing board and appoint a disciplinary subcommittee.

During an investigation or after a complaint has been issued, LARA may schedule a compliance conference. If an agreement is not reached, LARA must schedule a hearing. A compliance conference or a hearing may include one member of the appropriate board or task force who is not a member of the disciplinary subcommittee with jurisdiction over the matter, and such a person may attend a hearing. Under the bill, if the A.P.R.N. Task Force were the disciplinary subcommittee with jurisdiction, a compliance conference could include a Task Force member, and a Task Force member could attend a hearing.

License Fees

The fees for an individual licensed or seeking licensure to practice nursing as an R.N. include a \$24 application processing fee and a \$30 annual license fee. For a specialty certification for an R.N., the Code prescribes an application processing fee of \$24 and an annual specialty certification fee of \$14.

The bill would retain these fees and prescribe the following fees for an individual who sought or held a license as an advanced practice registered nurse under Part 172:

- An application processing fee of \$32.
- An annual certification fee of \$55.

The Department and the A.P.R.N. Task Force would be required to review these fees every two years. The Department could, by rule and with the consent of the Task Force, adjust the fees to reflect expenses regarding issuing A.P.R.N. licenses, and program administration.

License Renewal

The bill would permit the Board of Nursing, by rule, to require a licensee seeking renewal of a license under Part 172 to give the Board satisfactory evidence that, during the two years immediately before the date of the renewal application, he or she completed continuing education or competency courses or activities approved by the Board. If the Board did so, it would have to promulgate rules requiring each applicant for license renewal to complete as part of those courses or activities an appropriate number of hours or courses in pain and symptom management.

Board of Nursing

Currently, the Board of Nursing consists of the following 23 voting members:

- Nine registered professional nurses.
- One nurse midwife.
- One nurse anesthetist.
- One nurse practitioner.
- Three licensed practical nurses.
- Eight public members.

The bill would increase the total number of members to 29, beginning 60 days after its effective date. In addition to the nine R.N.s and the three licensed practical nurses, the Board would have to include two certified nurse midwives, two nurse anesthetists, two certified nurse practitioners, two clinical nurse specialist-certifieds, and nine public members.

Currently, the nurse midwife and nurse practitioner members must each have a specialty certification issued by LARA in his or her respective specialty field. Under the bill, each appointed C.N.M., C.N.P., and C.N.S.-C. would have to have an A.P.R.N. license issued by LARA in his or her respective role, and each of the nurse anesthetists would have to have a specialty certification issued by LARA in that specialty field.

Other Provisions

Under the Code, a speech-language pathology licensee may perform assessment, treatment or therapy, and procedures related to swallowing disorders and medically related communication disorders only on patients who have been referred to him or her by a person licensed in the practice of medicine or osteopathic medicine and surgery. The bill would include a patient referred by a licensed A.P.R.N. engaged in the practice of advanced practice registered nursing.

Currently, occupational therapy services include the provision of vision therapy services or low vision rehabilitation services, if the services are provided pursuant to a referral or prescription from, or under the supervision or comanagement of, a licensed physician or optometrist. Under the bill, these services also could be provided pursuant to a referral or prescription from a licensed A.P.R.N. engaged in the practice of advanced practice registered nursing.

The Code prohibits a person from engaging in the practice of physical therapy or practice as a physical therapist assistant unless licensed or otherwise authorized. A person may engage in the actual treatment of an individual only upon the prescription of an individual holding a license issued under Part 166 (Dentistry), 170 (Medicine), 175 (Osteopathic Medicine and Surgery), or 180 (Podiatric Medicine and Surgery). Under the bill, a person holding an A.P.R.N. license, while engaged in the practice of advanced practice registered nursing, also could prescribe physical therapy.

The Code requires licensed health facilities and agencies to adopt a policy describing the rights and responsibilities of patients or residents. The policy must contain specific provisions, including that a patient or resident is entitled to be free from physical and chemical restraints, except those authorized in writing by the attending physician or physician's assistant. Under the bill, restraints also could be authorized by an A.P.R.N. engaged in the practice of advanced practice registered nursing.

MCL 333.2701 et al.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The bill would allow R.N.s to practice to the full extent of their education and training, by recognizing A.P.R.N.s, and removing barriers such as mandatory oversight by a licensed physician. This could result in a more competitive environment for health care that, in turn, would lower costs for consumers, promote greater access to health care professionals, and spur innovation.

A 2010 report by the Institute of Medicine examined the state of the nursing profession and made several recommendations. One of the recommendations was to allow nurses to practice to the full extent of their education and training. Since regulations vary greatly across states, nurses are effectively limited in practice based on the local laws, not on their qualifications. Given the current shortage of health care providers, and the imminent ramifications of the Affordable Care Act, demand for health care professionals will increasingly exceed supply. Failing to allow nurses to practice based on their education and training will create a bottleneck, resulting in underutilization of nurses, and therefore, opportunity cost. According to a representative of the Advanced Practice Registered Nurse Coalition (APRNC), underutilization of nurses costs the U.S. \$9 billion annually.

The current model of delegated authority limits consumer access to affordable quality health care, particularly in rural areas, and areas designated as health professional shortage areas (HPSAs). An Annals of Family Medicine 2003 study of health care professionals in California and Washington showed that, when compared with licensed physicians, a higher proportion of C.N.P.s and C.N.M.s tended to work in rural areas and HPSAs. Additionally, the study showed that nonphysician primary care clinicians, and family physicians, were more likely to care for underserved populations than specializing physicians. According to the U.S. Department of Health and Human Services, as of March 28, 2014, 73 out of 83 counties in Michigan contained medically underserved areas or populations, and 80 counties contained designated HPSAs with regard to primary care clinicians.

Recognizing A.P.R.N.s' enhanced scope of authority also could increase future access to health care professionals by potentially offsetting impending health care practitioner shortages. As baby boomers age and retire, there will be higher demand for medical services, and the number of physicians retiring will exacerbate the need for providers. According to a study by the Center for Health Workforce Studies on current trends, the State will be short 4,400 primary care physicians in 2020.

Furthermore, the use of A.P.R.N.s would decrease costs. When compared with licensed physicians, according to the representative from the APRNC, nurse practitioners and midwives typically prescribe fewer drugs, order fewer expensive tests, and use lower-cost treatment. A 2011 Federal Trade Commission (FTC) memo also suggested that while A.P.R.N. care is already generally less expensive than licensed physician care, greater autonomy for A.P.R.N.s would reduce administrative burdens for them, resulting in lower operating costs that could be passed on to consumers in the form of lower prices.

In addition, restrictions that prevent A.P.R.N.s from practicing based on their education and certification give these professionals an incentive to leave the State for work in areas that uniformly recognize that A.P.R.N.s may practice without licensed physician supervision. The medical care industry is important to the Michigan economy, and the State competes for health care services just as it does for any other business industry. Enabling A.P.R.N.s to practice to the full extent of their education, training, and certification would encourage them to stay in, or move to, Michigan.

Finally, by giving A.P.R.N.s statutory recognition and providing for their regulation, the bill would protect the public from people who lack appropriate education and certification, and would prevent unqualified individuals from using the A.P.R.N. title.

Response: The bill would hold an A.P.R.N. to the standard of care or practice that applies to a physician, in an action for malpractice or license removal, if the A.P.R.N. practiced without the supervision of a physician. Rather than making Michigan more attractive to A.P.R.N.s, this provision would discourage them from practicing in this State. If it did not undermine the bill altogether, the language would create an atmosphere of uncertainty because the meaning of "supervision" is unclear.

Opposing Argument

Although the bill could improve patients' access to health professionals, it would reduce the quality of health care patients receive. The bill would functionally permit A.P.R.N.s to act as physicians, since it would allow A.P.R.N.s to practice independently of physician oversight, and prescribe drugs. The minimum standard for practicing medicine is the ability to make a diagnosis, and prescribe drugs. By permitting A.P.R.N.s to do both of these, the bill effectively would allow them to practice medicine without the appropriate education, certification, and training.

According to the Primary Care Coalition, licensed physicians' standards of education, rigorous testing, and residency requirements culminate in roughly 20,000 hours over a decade of instruction and training. Nurse practitioners, in contrast, have no residency requirements, and receive roughly 3,000 to 5,000 hours over five-and-a-half to six years of instruction and training. Since their training and education are less comprehensive and consistent than physicians', A.P.R.N.s should be subject to licensed physicians' oversight. Through a collaborative relationship, overseeing physicians are in the best position to ensure that A.P.R.N.s practice to the fullest extent of their education and training. Under the bill, physicians would lack this oversight. Even when an A.P.R.N. had to have a mentorship agreement, it would not have to be with a physician.

Also, allowing A.P.R.N.s to practice without supervision could increase health care costs. Since these individuals are less qualified than physicians, they may be uncertain about diagnosing and prescribing. This could result in unnecessary tests and prescriptions, which would raise health care costs. Further, overprescribing and excessive testing can have other repercussions, such as threats to patient safety and well-being. According to a report by the Josiah Macy Jr. Foundation, a review of over 900 articles and documents over 30 years concluded that nurse practitioners ordered more lab tests than physicians ordered.

Since the ultimate responsibility for a patient's well-being rests with the physician, allowing A.P.R.N.s to act as physicians could radically alter, and challenge, the medical care landscape.

Response: The report by the Josiah Macy Jr. Foundation also indicated that, compared with licensed physicians, nurse practitioners had higher patient satisfaction and resolution of pathological conditions, spent more time with patients, made more referrals, and had fewer patients hospitalized. Nurse practitioners and physicians were equivalent with regard to patients' overall quality of care, prescription of drugs, and number of visits. In addition, according to the 2011 memo issued by the FTC, restrictions on A.P.R.N. practice typically exceed what is necessary to protect consumers.

Legislative Analyst: Suzanne Lowe

FISCAL IMPACT

The bill would have an indeterminate effect on State finances, and no fiscal impact on local government. Under the bill, an individual seeking licensure as an advanced practice registered nurse would have to pay an application processing fee of \$32 and an annual license fee of \$55. It is unknown how many individuals would apply and seek licensure, but revenue from the fees would be credited to the Health Professions Regulatory Fund and used for costs associated with issuing the licenses.

The Department of Licensing and Regulatory Affairs would be responsible for some increased costs related to processing applications and issuing licenses as prescribed by the bill. It is unknown whether the fees in the bill would be sufficient to cover the Department's expenses, so the fiscal impact is indeterminate.

Fiscal Analyst: Josh Sefton

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.