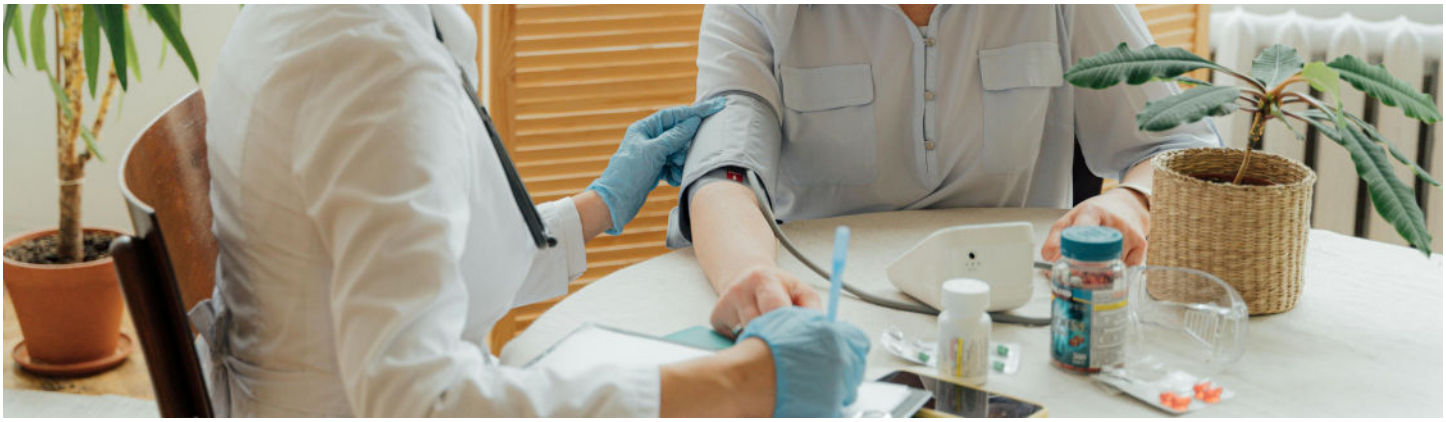


# RESTRICTIONS TO CARE:

## How Collaborative Practice Agreements for Advanced Practice Registered Nurses and Certified Nurse-Midwives Limit Patient Access

Caitlin Styrsky, Donna Matias, and Jaimie Cavanaugh

Advanced practice registered nurses (APRNs) are among the most qualified and versatile health practitioners. APRNs have education and training in a specialized medical field that allows them to perform tasks beyond the scope of a registered nurse, such as diagnosing and treating patients or prescribing medications.

APRNs play a critical role in increasing patient access to care through their work in community settings and rural areas. A 2022 report from the Medicare Payment Advisory Commission finds that APRNs and physician assistants make up half of the primary care workforce in rural areas and one-third of the primary care workforce overall.[1] As of 2024, the United States had a shortage of an estimated 124,000 physicians,[2] making the work of APRNs in rural and community settings—especially communities with low socioeconomic health status—pivotal to increasing patient access to care.[3]

While some states allow APRNs to practice independently, other states require APRNs to enter into a collaborative practice agreement (CPA) or a similar supervisory relationship with a physician. CPA restrictions, such as limiting an APRN's practice to a group or hospital setting, can prove frustrating for entrepreneurial APRNs seeking to practice independently. This research in brief compares CPA requirements throughout the United States for APRNs, focusing on nurse practitioners (NPs) and certified nurse-midwives (CNMs). In addition, it analyzes the effect of these requirements on healthcare competition and patient access to care.

## Introduction to Collaborative Practice Agreements

A CPA is a legally binding contract between a health professional, such as an APRN, and a licensed physician that outlines the parameters of the health professional's practice and the physician's role. While an APRN's scope of practice is generally defined by state statutes or regulations, CPAs and similar supervisory relationships can further constrain an APRN's practice authority by stipulating practice settings, permitted medical functions, or prescriptive authority. These agreements may also establish physician supervision requirements, such as consultations and patient record reviews.[4]

For APRNs, the specific structure of CPAs varies by state. Some states require comprehensive agreements covering all aspects of APRN practice, while other states limit required agreements to prescribing authority or other specific functions.[5] CPAs may also provide a path to independent practice once an APRN completes a mandated number of supervised clinical hours. California law, for example,

requires NPs who desire independent practice to complete 4,600 "transition to practice" hours. Doing so earns them the title "103 NP." These 103 NPs are free to work without a CPA but may only do so in a group setting. While some might choose to remain in this setting, those NPs who wish to become fully independent—called "104 NPs"—must complete another 4,600 clinical hours in a group setting.

In other cases, CPAs control where APRNs are allowed to practice. Nebraska law, for example, prevents CNMs from practicing outside of hospitals or group settings, making it illegal for CNMs to attend home births. Such variations influence the degree of oversight and autonomy APRNs have within their specialized fields.[6]

CPA advocates argue that the agreements serve as a regulatory tool to streamline supervision, interdisciplinary collaboration, and liability management.[7] CPAs, according to this view, formalize the working relationship and responsibilities between APRNs and physicians,[8] provide a mentorship framework for newly certified APRNs,[9] and reduce liability risk.[10]

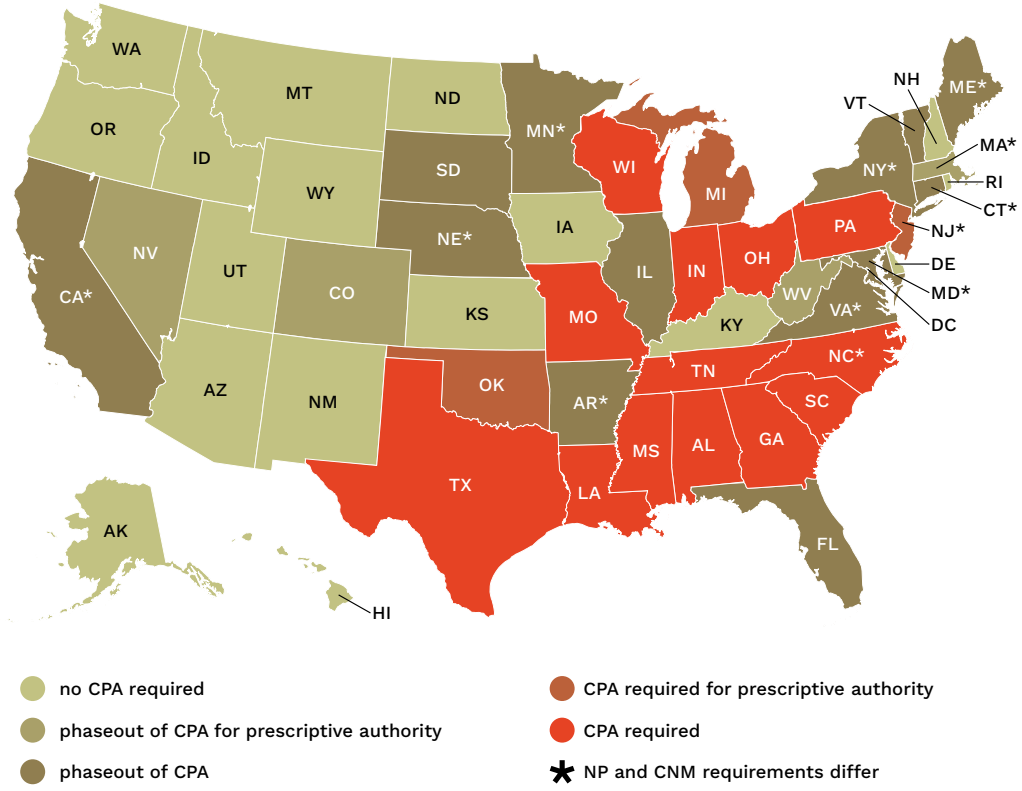
## Laws Governing Collaborative Practice Agreements in the States

State CPA requirements for NPs and CNMs fall into five categories:

- *CPA not required.* NPs and CNMs can practice independently, and a CPA is not required.
- *CPA required.* NPs and CNMs must have a CPA in place to practice. Independent practice is not permitted.
- *CPA with transition to independent practice.* NPs and CNMs are required to have a CPA for a specific period. After working a number of hours under physician supervision, APRNs can practice independently.
- *CPA required only for prescriptive authority.* NPs and CNMs are required to have a CPA in place to prescribe certain medications or controlled substances.
- *CPA for prescriptive authority with transition to independent practice.* NPs and CNMs must have a CPA for prescriptive authority during the initial supervisory period. Once these APRNs satisfy the supervisory period, they may practice and prescribe independently.

Although NPs and CNMs are most often regulated in the same way, a handful of states have separate require-

**Figure 1. Collaborative Practice Agreements for Nurse Practitioners by State**




Note: CNM = certified nurse-midwife. CPA = collaborative practice agreement. NP = nurse practitioner.
Source: See Appendix A.

**Table 1. Requirements for Certified Nurse-Midwife and Nurse Practitioner Collaborative Practice Agreements (in States Where Those Requirements Differ)**

| | CNM CPA Requirement | NP CPA Requirement |
|---|---|---|
| Arkansas | CNMs have full practice authority. | NPs must complete 6,240 hours of practice with a physician under a CPA before transitioning to independent practice. |
| Connecticut | CNMs are registered nurses with a midwifery certification and are regulated separately from APRNs. CNMs are not required to have a CPA, but they must practice within a healthcare system and have clinical relationships with physicians. | NPs must have a CPA with a licensed physician for three years and 2,000 hours of practice before transitioning to independent practice. |
| California | CNMs have full practice authority for low-risk births. More complicated cases require a CPA. | NPs must practice for three years in a group setting, where a CPA with physician supervision is not required, before gaining full practice authority as a 104 NP. |
| Minnesota | CNMs have full practice authority. | NPs must practice under a CPA for 2,080 hours before transitioning to independent practice. |
| Maryland | CNMs have full practice authority. | NPs must have a mentor, either another NP or a licensed physician, with whom they can collaborate and consult for 18 months before transitioning to independent practice. |
| Maine | CNMs have full practice authority. | NPs must practice for 24 months under the supervision of a physician, another NP, or within a group or hospital setting before transitioning to independent practice. |
| Massachusetts | CNMs have had full scope of practice in Massachusetts since 2012 and do not legally require physician supervision to practice, prescribe, or bill. However, they must practice within a healthcare system and have clinical relationships with physicians. | NPs require a CPA for prescriptive authority that phases out after two years. |
| New York | CNMs have independent practice authority. They are not required to have a written collaborative agreement but must maintain a collaborative relationship with a physician or hospital. | NPs must have a CPA that transitions to independent practice after 3,600 hours. Effective July 1, 2026, NPs with full practice authority must maintain a documented collaborative relationship with a physician, but a formal practice agreement is not required. |
| Virginia | CNMs must complete 1,000 hours in a CPA with another experienced CNM or physician before transitioning to independent practice. | NPs must have a CPA for three years (5,400 practice hours) before transitioning to independent practice. |
| North Carolina | CNMs must maintain a CPA for 4,000 practice hours before transitioning to independent practice. | NPs must practice under a CPA. |
| New Jersey | CNMs must maintain a CPA, known as a consulting agreement. | NPs need a CPA for prescriptive authority. |
| Nebraska | CNMs must practice under a CPA. | NPs must practice under a CPA for 2,000 hours before transitioning to independent practice. |

Source: See appendix A.

ments for CNMs. Figure 1 shows the CPA requirements in each state and shows which states have different CPA requirements for CNMs.

Thirty-five states and the District of Columbia allow APRNs to practice independently. Of these states, 17 require an initial CPA or similar supervisory relationship that transitions to independent practice authority after the APRN satisfies a specified hourly requirement under physician supervision. The hourly requirement ranges from 1,000 hours for CNMs in Virginia to 6,240 hours for NPs in Arkansas. Of the states that offer a path to independent practice, 13 have full CPA requirements, and four have CPA requirements for prescriptive authority only.

Sixteen states require APRNs to practice under a CPA. Of these states, 13 require a CPA for full practice, and three require a CPA for prescriptive authority only.

While most states demonstrate alignment between CPA requirements for NPs and CNMs, 12 have different CPA requirements for each. Table 1 identifies the states with these differences and the specific requirements for NPs and CNMs.

## How Collaborative Practice Agreements Hurt Providers and Patients

Despite their purported benefits, CPAs can have several negative policy implications that undermine their intended purpose, including limiting healthcare options for patients and restricting entrepreneurial opportunities for nurses seeking to earn a living independently.

The challenges associated with establishing and maintaining CPAs can create significant professional barriers for APRNs. The difficulties in finding a collaborating physician and maintaining the agreement can disincentivize entrepreneurial APRNs from establishing their own practices. Moreover, some nurses have reported interruptions in their practices when a physician relocates, retires, or decides to no longer participate in a CPA. These situations can leave APRNs scrambling to find new partnering physicians and establish new agreements, and this process often hinders patient access to care.

A 2020 survey of mental health APRNs, for example, finds that more than one-third of nurses had experienced a disruption in their CPA.[11] In situations in which patients form strong trust bonds with their providers, this can be distressing. In rural areas where healthcare options are already limited, CPA interruptions can further reduce provider options.

The fees that APRNs must pay physicians to establish or maintain a CPA can further disincentivize entrepreneurial APRNs from working in states with CPA requirements. A 2019 survey of APRNs across 29 states finds that the one-time fees required to establish a new CPA averaged $650, ranging from as low as $10 to as high as $50,000. On top of the initial establishment fee, the additional monthly fees required to maintain the CPA averaged $500, ranging from $4 to more than $4,000. These fees create financial obstacles for many APRNs seeking to enter independent practice, raising prices and limiting healthcare options for patients.[12]

Despite charging substantial fees, not all supervising physicians provide APRNs with meaningful oversight, raising questions about the quality and necessity of CPA supervision. Forty to fifty percent of respondents to the 2019 survey had irregular communication with their supervising provider and received no formal review of their medical records.[13] The paperwork and administrative burdens of maintaining a CPA, moreover, take time away from practitioners' provision of patient care and add unnecessary complexity to healthcare services.[14] A 2017 study, for example, finds that independent practice authority for NPs increases the amount of time physicians spend providing patient care, suggesting that eliminating CPA administrative burdens allows multiple types of providers to devote more time to patients.[15] And a 2023 study finds that rather than minimizing malpractice claims, relaxed practice restrictions on APRNs result in a 21–24 percent reduction in physician malpractice rates, with no increase in NP malpractice claims.[16]

CPAs can create additional barriers to entry, particularly for entrepreneurial CNMs. Nebraska, for example, not only requires a CPA but also mandates that CNMs practice only in hospitals or settings authorized by their collaborating physician. This limits the ability of highly skilled CNMs to provide services to women seeking alternative or home birth options.

CPAs are correlated with smaller APRN workforces, higher costs, and reduced patient access to care.[17] These agreements add an additional layer of bureaucratic oversight to the APRN profession, which is already regulated by state boards of nursing.[18] Through fees, practice restrictions, and administrative burdens, CPAs ultimately limit healthcare delivery, especially in rural and underserved areas.

## How Independent Practice Authority Improves Health Outcomes

APRNs in independent practice have patient outcomes comparable to those of physicians, experience high levels of satisfaction among their patients, and increase access to healthcare in underserved communities.[19] States that grant APRNs full practice authority show increased access to healthcare and more cost-effective treatment.[20] A 2017 study finds that patients in states with independent NPs reported more convenient appointment scheduling, reduced travel times, and increased access to a consistent care provider.[21] The same study estimates that the increased availability of NPs in medically underserved communities would result in a 30 percent increase in access to primary care services.[22] In addition, walk-in clinics offering non-emergency care, known as retail clinics, are often staffed by NPs and have lower associated costs per visit than visits to emergency rooms or hospitals. A 2013 study finds even lower costs for visits to retail clinics staffed by NPs in states in which NPs had independent practice authority. The study estimates $1.8 billion in cost savings through retail clinic visits and an additional $810 million in savings if all states were to allow for independent NP practice.[23]

The counties along the Maryland–Pennsylvania border show the effects of independent NP practice authority on patient access to care. NPs in Maryland have had independent practice authority since 2015, whereas NPs in Pennsylvania must practice under physician supervision. A 2022 report from the Commonwealth Foundation finds that Maryland's transition to independent NP practice resulted in statistically significant increases in NP provider density per 100,000 residents. The report concludes that transitioning to independent NP practice in Pennsylvania could increase access to primary care by 1,792 patients per week and reduce the number of medically underserved communities in the state.[24] A similar study from the Knee Regulatory Research Center from 2024 examines healthcare access in North Carolina after Virginia allowed NPs to practice independently in 2018. The study finds that many North Carolina NPs chose to work instead in neighboring Virginia, resulting in a 20 percent decline in NPs per 100,000 residents in interior North Carolina counties and an increase in poor resident health.[25]

Full practice authority for CNMs improves women's access to care and supports birth options outside hospital settings. Like APRNs more broadly, independent CNMs have patient outcomes comparable with those of physicians.[26] Full practice authority for CNMs has also contributed to a rise in CNM-attended births. Because many CNMs attend births in home settings and birth centers outside of hospitals, allowing CNMs to practice independently increases women's access to birth options, with no negative impact on health or safety. Granting full practice authority for CNMs has had little impact on maternal mortality, obstetric outcomes, or neonatal mortality.[27] CNMs offer more cost-effective services and lower-intensity obstetric care, reducing interventions and complications.[28] One study found a 7.5 percent reduction in C-section rates for women in states where CNMs have independent practice authority, suggesting potential nationwide savings of more than $101 million a year.[29] In fact, many wealthy countries, including Australia, Canada, the Netherlands, and the United Kingdom, have midwifery-led models of care that demonstrate high patient satisfaction rates and improved health outcomes.[30]

Research into the behavioral health sector has reached similar conclusions, finding positive patient outcomes for mental health and psychiatric APRNs and bolstering support for independent practice authority. A 2017 analysis of community health center data from the National Ambulatory Medical Care Survey, for example, concludes that mental health APRNs were likelier than physicians to offer care to rural communities and special populations, including women, minorities, and individuals with disabilities.[31] A separate study finds that adults with major depression treated by psychiatric APRNs reported being highly satisfied with the care they received.[32] In states with full practice authority, mental health APRNs play a pivotal role in expanding access to care in rural and underserved areas.[33]

## Legal Challenges to Collaborative Practice Agreement Mandates

In Nebraska, CNM Heather Swanson is, with the help of the Pacific Legal Foundation, challenging a state law that mandates a CPA with the strictest provisions in the country. CNMs in Nebraska must practice under physician supervision and can only practice within hospitals or settings authorized by their collaborating physician, unlike other types of midwives, who typically have less training but can work outside of hospitals. These restrictions not only limit the ability of CNMs to earn a living in the state but also prevent pregnant women from having formally trained medical professionals attend their home births. In *Swanson v. Hilgers*,[34] Swanson argued that the law mandating a CPA violates the Due Process Clause, the Equal Protection Clause, and the Privileges and Immunities Clause of the Fourteenth Amendment by arbitrarily restricting the rights of Nebraska CNMs to provide in-home childbirth care to expectant mothers.

In California, NPs Kerstin Helgason and Jamie Sorenson care for vulnerable mental health patients in solo practices that nonetheless require a CPA with a physician by law. The two NPs are, with the help of the Pacific Legal Foundation, challenging the State Board of Registered Nursing's interpretation of a 2020 California law that effectively eliminates their ability to continue their solo practices if they hope to transition to independent practice.[35] The path to independent practice established by the law entails practicing for three years in a group setting, such as a hospital, forcing Helgason and Sorenson to leave their existing solo practices and disrupt their patients' care, only to open back up once they have achieved independent status. In *Helgason v. California Board of Registered Nursing*, Helgason and Sorenson argue that the board's interpretation of the law violates the Equal Protection Clause and the Due Process Clause of the Fourteenth Amendment by preventing qualified APRNs from pursuing their chosen profession free from unreasonable government interference.

## Conclusion

Whereas more than half of states allow for independent practice or provide a path to independent practice for APRNs, 16 states still mandate CPAs that decrease competition and patient access to care. By reducing CPA requirements, these states could boost innovation, healthcare access, and entrepreneurship among APRNs.

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