Montana Department of LABOR & INDUSTRY

Licensing Reform Task Force

Healthcare Subcommittee

NURSING CAREER LADDERS AND APPRENTICE LICENSING

Executive Summary

Montana has a strong opportunity to build practical nursing career ladders using existing statutory tools, existing Board of Nursing credentials, registered apprenticeship, and targeted education-program partnerships. The best near-term policy is not to create a broad new category of independently billable nurse apprentices. Instead, the Healthcare Subcommittee may consider recommending development of **two linked nursing career-ladder pilots**:

1. CNA-to-LPN Career Ladder Pilot: CNA → Medication Aide II → advanced delegated-skill endorsements → practical nursing apprentice/bridge curriculum → NCLEX-PN → LPN.

2. LPN-to-RN Career Ladder Pilot: LPN → RN apprentice/bridge curriculum → NCLEX-RN → RN.

Both pathways should preserve existing licensure standards, including Board oversight and NCLEX passage. Apprenticeship should be used primarily as an **education, supervision, rural-access, and retention tool**. Apprentice licensing may help with title clarity, scope limits, supervision standards, competency tracking, and employer confidence. It should not be assumed to create billable services.

On reimbursement, the most defensible conclusion is that apprentice licensing is **necessary but not sufficient**. It may help identify who the apprentice is and what the apprentice may do, but Medicaid and private payers will still require a covered service, recognized provider type, supervision rule, and payment methodology. The Healthcare Subcommittee therefore may consider separating the **career-ladder licensing work** from a **DPHHS-led reimbursement feasibility process**.

Main Questions Presented

This paper addresses two related questions:

1. What are the best policy options for nursing career ladders in Montana, using existing pathways and authorities?
2. How would, or could, apprentice licensing help with insurance reimbursement, including private insurance and Medicaid?

Background

Materials from the Licensing Reform Task Force meetings and public comments show sustained interest in CNA-to-LPN-to-RN pathways as a healthcare workforce strategy. Public comments included a proposal from an experienced CNA/CPHT for a competency-based LPN pathway for experienced CNAs, identifying barriers such as limited rural program availability, waitlists, financial constraints while working full-time, and repetition of entry-level content already practiced safely for years.

The June 8 healthcare session agenda expressly included **CNA-to-LPN-to-RN** pathways under apprenticeship, education pathways, and licensing-adjacent barriers. It directed discussion toward whether apprentice licenses, trainee licenses, tiered credentials, mentor endorsements, or other licensing tools would improve healthcare pathways.

The discussion on June 8 frames the issue as exploratory, not settled. The recurring question is whether apprentice or trainee credentials could solve billing, reimbursement, supervision, rural workforce, and employer-sustainability barriers where a worker is progressing through apprenticeship but is not yet fully licensed. The discussion is focused less on "licensing apprentices" as an end in itself and more on whether a license/ credential could help solve billing, reimbursement, supervision, rural workforce, and employer-sustainability barriers.

Montana Legal Foundation

Montana already has a strong statutory basis for nursing apprenticeship pathways. Section 37-1-148, MCA provides that a board or program shall grant listed licenses to a person who completes an apprenticeship program under Title 39, chapter 6, in the relevant occupation or profession, and that apprenticeship applicants must meet the same exam and fee requirements as education-program applicants. The Board of Nursing licenses listed in the statute include **licensed practical nurse**, **medication aide II**, and **registered nurse**.[1]

Montana's nursing definitions also provide the guardrails for pathway design. Montana defines Medication Aide I and Medication Aide II, recognizes practical nursing and professional nursing as distinct scopes, and defines nursing education programs as Board-approved schools preparing graduates for initial licensure.[2] Medication Aide I practice is limited to services requiring basic knowledge of medication administration under Board-determined circumstances, in licensed assisted living, under general supervision of a licensed professional or practical nurse.[3]

The legal design principle should be simple: **recognize progression without authorizing independent practice before licensure**. Intermediate credentials may document supervised competencies, but they should not permit CNAs to practice practical nursing, or LPNs to practice professional nursing, before reaching the appropriate licensure endpoint.

[1] 37-1-148, MCA
[2] 37-8-102, MCA
[3] 37-8-422, MCA

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Policy Option 1: CNA-to-LPN Career Ladder

Recommended model

The Healthcare Subcommittee may consider a recommendation to create a **CNA-to-LPN Career Ladder Pilot** that allows experienced CNAs to progress through stackable credentials and supervised competencies while preserving the LPN license as the endpoint.

Recommended pathway:

Stage	Credential / Milestone	Function	Safeguards
1	**CNA in good standing**	Entry point for experienced direct-care workers	Registry verification, employer attestation, background check, discipline/abuse-registry review
2	**Medication Aide I or Medication Aide II**, as applicable	Adds medication-administration competency within current statutory limits	Board-approved training, exam, nurse supervision, setting-specific scope
3	**Advanced CNA Skills Endorsement: Skin Integrity and Wound Observation**	Documents competency in pressure-injury prevention, skin checks, delegated dressing support, and reporting	Does not authorize independent wound treatment; RN/LPN delegation and facility protocol required
4	**Advanced CNA Skills Endorsement: Nutrition and Tube-Feeding Support**	Documents competency in feeding assistance, aspiration precautions, tube-site observation, and delegated support tasks	Does not authorize independent tube placement, assessment, or clinical judgment
5	**Practical Nursing Apprentice / LPN Trainee**	Formalizes participation in a registered practical-nursing apprenticeship or bridge curriculum	Title 39 apprenticeship, Board rules, preceptor assignment, clinical log, progressive competency sign-off
6	**NCLEX-PN eligibility and LPN application**	Candidate completes required curriculum/apprenticeship milestones and applies for LPN licensure	Same exam and fee requirements as other applicants; Board review before authorization to test
7	**Licensed Practical Nurse**	Full LPN practice under Montana law	Standard LPN licensure, renewal, discipline, and continuing competency requirements

Why this option fits Montana

This model fits Montana better than a pure "challenge the LPN exam" approach because Montana already recognizes Medication Aide II and LPN apprenticeship licensure. It also responds to comments that experienced CNAs should receive recognition for safe, long-term practice without reducing RN/LPN/CNA standards.

Other-state models

California provides the strongest CNA-to-LVN comparator. California workforce materials describe a **CNA and CNA-to-LVN Apprenticeship Program**, and California recognizes an LVN equivalency method for certain applicants with extensive inpatient bedside experience and formal education. See California Workforce Development Board, CNA and CNA to LVN Apprenticeship Program, and California Board of Vocational Nursing and Psychiatric Technicians, Method 3: Qualification Based on Equivalent Education and/or Experience.

Missouri provides a strong stackable-credential example through medication-aide and challenge processes. Missouri's Certified Medication Technician program prepares individuals to administer non-parenteral medications to assist LPNs or RNs, and Missouri also has a Level I Medication Aide program and CNA challenge process. See Missouri Department of Health and Senior Services, Certified Medication Technician Program, Level I Medication Aide, and CNA Challenge.

Best policy choice

Montana could pursue a **rule-based pilot using existing apprenticeship authority**, with a legislative backstop if the Board concludes new advanced CNA endorsements or LPN trainee titles need explicit statutory authorization. The pilot could begin with long-term care, rural hospital, and critical-access employers and should require no waiver of NCLEX-PN or Board licensure standards.

Policy Option 2: LPN-to-RN Career Ladder

Recommended model

The Healthcare Subcommittee may consider a recommendation to create an **LPN-to-RN Career Ladder Pilot** built around a Board-approved LPN-to-RN bridge curriculum, registered apprenticeship, supervised clinical progression, and preservation of **NCLEX-RN** as the licensure endpoint.

Recommended pathway:

Stage	Credential / Milestone	Function	Safeguards
1	**LPN in good standing**	Entry point for licensed practical nurses	Montana license verification, discipline review, employer attestation
2	**Bridge-readiness assessment**	Identifies gaps in science, pharmacology, assessment, care planning, leadership, and RN scope	Board-approved assessment; no independent RN practice
3	**LPN-to-RN bridge curriculum enrollment**	Candidate enters Board-approved ADN, LPN-to-RN, or RN apprenticeship-aligned education program	Education-program approval; credit for prior LPN learning where appropriate
4	**RN Apprentice / Professional Nursing Apprentice Registration**	Formalizes employer-sponsored apprenticeship while candidate completes RN pathway	Title 39 apprenticeship, Board rules, RN preceptor assignment, title clarity
5	**Progressive RN competency milestones**	Documents supervised growth in RN competencies	Clinical log, RN sign-off, competency limits, no independent RN assessment or care planning until licensed
6	**NCLEX-RN eligibility and RN application**	Candidate completes curriculum/apprenticeship milestones and applies for RN licensure	Same exam and fee requirements as other applicants; Board authorization to test
7	**Registered Nurse**	Full professional nursing practice	Standard RN licensure, renewal, discipline, and continuing competency requirements

Why this option fits Montana

LPN-to-RN apprenticeship is structurally easier than CNA-to-RN because the candidate is already licensed, already practicing nursing, and already subject to Board discipline. The issue is how to recognize progression toward RN-level competencies without blurring the line between practical nursing and professional nursing.

The pathway should focus on competencies that distinguish professional nursing from practical nursing, including:

- RN assessment and nursing analysis;
- care planning and evaluation;
- leadership, supervision, and delegation;
- RN-level medication and treatment management;
- care transitions, documentation, and quality reporting.

Other-state models

Wisconsin provides the strongest official RN apprenticeship model. Wisconsin's Department of Workforce Development describes a **Registered Nurse apprenticeship pilot** aligned with the Wisconsin Technical College System associate-degree nursing pathway. See Wisconsin Department of Workforce Development, Registered Nurse Apprenticeship, and Apprenticeship.

Washington provides useful nursing-apprenticeship infrastructure through an official LPN apprenticeship pilot and standards. See Washington Office of Financial Management, LPN Registered Apprenticeship Pilot, and Washington apprenticeship standards, LPN Apprenticeship Program Standards.

Maryland provides a useful implementation model through healthcare apprenticeship workgroup materials. See Maryland Department of Health, Maryland Registered Apprenticeship Presentation, and Maryland Department of Labor, Healthcare Apprenticeship Workgroup Report.

Best policy choice

Montana could pursue a **Board-approved LPN-to-RN bridge with registered apprenticeship**, plus a limited **RN Apprentice Registration** only for tracking, title clarity, supervision standards, and workforce data. The registration should not authorize independent RN practice or direct billing unless DPHHS, CMS, and affected payers determine that a reimbursement pathway is legally and fiscally feasible.

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Apprenticeship Licensing and Insurance Reimbursement

Core conclusion

Apprentice licensing may be useful for nursing career ladders, but it should not be treated as automatically making apprentice services billable. Apprentice licensing can help define:

- title and role clarity;
- supervision requirements;
- limits on scope;
- competency milestones;
- employer and preceptor accountability;
- data reporting; and
- patient-safety protections.

But reimbursement is a separate question. A payer will still need a covered service, recognized provider type, supervision structure, documentation rule, and payment methodology. The task force materials correctly identify billing as the practical test for any apprentice model.

Medicaid

Medicaid is the more plausible reimbursement pathway, but only through DPHHS-led design and, where necessary, CMS approval. DPHHS explained during the June 8 healthcare session of the task force meeting that Medicaid services generally must be delivered by recognized provider types, within licensed scope, and consistent with federal and state Medicaid rules. Trainees, apprentices, and in-training professionals generally must operate under supervision and are generally not eligible to bill Medicaid directly.

The RN context is especially difficult because DPHHS indicated that RN services may already be accounted for in RVU/RBRVS reimbursement methodology, making it hard to add separate reimbursement for RN apprentices.

The most realistic Medicaid options are therefore:

1. **No direct apprentice billing.** Apprentices continue to work under their current role or license, and employers treat apprenticeship as workforce investment.
2. **Supervised trainee service category.** DPHHS defines a narrow Medicaid-recognized trainee category for specific services, supervision rules, and settings.
3. **Credential-specific recognition.** DPHHS evaluates whether intermediate credentials, especially Medication Aide II or other Board-defined competencies, can be recognized within long-term-care or facility payment structures.
4. **Facility rate or workforce-training support.** Medicaid explores rate-setting, add-on payments, or workforce-training support rather than paying nurse apprentices as independently billable providers.

Private insurance

Private insurance is the weaker reimbursement pathway. Research does not show a general private-payer model under which nurse apprentices become independently billable based solely on apprentice status. Private payer reimbursement would likely depend on payer contracts, credentialing requirements, facility billing arrangements, supervision rules, and whether the payer voluntarily recognizes a trainee category.

The June 8 healthcare session discussion also reflects private-payer concern that new apprentice reimbursement tiers could add system costs and increase premiums.

For Montana, private payer reimbursement should therefore be explored through voluntary pilot agreements, not assumed as a consequence of licensing.

Other-State Reimbursement Models for Trainee Roles

Research does not indicate a clean official model in which **nurse apprentices** are independently reimbursed by Medicaid or private insurance simply because they hold apprentice status. The usable models are adjacent Medicaid models for supervised trainee or provisional roles.

Washington: peer specialist trainee

Washington's Medicaid state plan recognizes **Certified Peer Specialist Trainees** as practitioners who may furnish certain rehabilitative services under supervision. See CMS/Washington SPA, WA-25-0001. This is a strong example of Medicaid covering a supervised trainee role when the state defines the role, service, qualifications, and supervision requirements.

Montana takeaway: If Montana wants Medicaid recognition for healthcare apprentices, DPHHS would need to define the covered service, apprentice qualifications, supervision rules, and billing methodology in a state-plan, waiver, or provider-manual framework.

Missouri: behavior technician transition

Missouri's Medicaid state plan allows behavior technicians to furnish covered services for a limited transition period while working toward Registered Behavior Technician status, under supervision. See CMS/Missouri SPA, MO-24-0003.

Montana takeaway: A time-limited, supervised trainee category is more defensible than an open-ended apprentice license. If used for nursing, it should be narrow, competency-based, and tied to a defined training period.

Virginia: pharmacy interns and technicians

Virginia's Medicaid state plan recognizes services furnished by licensed pharmacists, pharmacy interns, and pharmacy technicians under specified conditions. See CMS/Virginia SPA, VA-23-0014.

Montana takeaway: This model may be most useful for medication-related functions in the CNA-to-LPN ladder, particularly where Medication Aide II is already a defined Montana credential. It does not automatically translate to broad LPN or RN apprentice reimbursement.

CMS peer-support guidance and workforce-training toolkit

CMS guidance confirms that states may cover peer support services under Medicaid authorities such as rehabilitative services, preventive services, and waivers, if the service is properly defined and approved. See CMS, Medicaid and CHIP Coverage of Peer Support Services FAQ. CMS has also issued a direct-service workforce training toolkit discussing training and rate-setting strategies. See CMS, Coverage of Direct Service Workforce Training within Medicaid Policy and Rate Setting.

Montana takeaway: Medicaid is more likely to support nursing apprenticeship through a **covered-service, supervision, and rate-setting model** than through a broad rule that an apprentice license equals billable provider status.

Policy Options for Montana

Option A: Career ladders without new apprentice licenses

Montana could ask the Board of Nursing, DLI, employers, and education programs to implement CNA-to-LPN and LPN-to-RN bridges using existing licenses, education-program approval, and apprenticeship rules, without creating new apprentice titles.

Strengths: Lowest regulatory risk; avoids new licensing barriers; preserves existing scopes.

Weaknesses: May not solve title clarity, competency tracking, employer sustainability, or reimbursement questions.

Option B: Limited apprentice registrations with no direct billing authority

Montana could create limited **Practical Nursing Apprentice** and **RN Apprentice** registrations for tracking, supervision, title clarity, and competency documentation. These registrations would not authorize independent practice or direct billing.

Strengths: Supports pathway integrity and employer confidence; avoids false reimbursement expectations; aligns with patient-safety concerns.

Weaknesses: Could become an administrative burden if not narrowly designed; may not create immediate financial sustainability.

Option C: Apprentice registrations plus Medicaid reimbursement feasibility pilot

Montana could create limited apprentice registrations and direct DPHHS to evaluate Medicaid reimbursement models, including supervised trainee categories, facility-rate support, or workforce-training add-ons.

Strengths: Directly addresses sustainability; uses Medicaid mechanisms that have analogues in other states.

Weaknesses: Legally and fiscally complex; may require CMS approval, state-plan amendments, rule changes, budget authority, and careful service design.

Option D: Broad apprentice billing category

Montana could attempt to create a broad apprentice billing category for nursing apprentices.

Strengths: Would directly respond to employer reimbursement concerns if successful.

Weaknesses: Not recommended. Research does not show a clean model for broad nurse apprentice billing, and the matter record flags Medicaid and private payer concerns. This approach risks creating new costs, new barriers, patient confusion, and payer resistance.

Recommended Policy Package

Montana could pursue a combined **Option B + targeted Option C** package:

1. **Create two nursing career-ladder pilots.**
   - CNA-to-LPN: CNA → Medication Aide II → advanced delegated-skill endorsements → LPN apprentice/bridge → NCLEX-PN → LPN.
   - LPN-to-RN: LPN → RN apprentice/bridge curriculum → NCLEX-RN → RN.
2. **Use apprentice registration for pathway integrity, not billing.**
   - Apprentice registrations should clarify title, supervision, competency tracking, and reporting.
   - They should not authorize independent practice or direct billing.
3. **Preserve licensure standards.**
   - No waiver of NCLEX-PN or NCLEX-RN.
   - No independent practical nursing by CNAs.
   - No independent professional nursing by LPNs or RN apprentices before RN licensure.
4. **Start with rural and long-term-care settings.**
   - These settings have the strongest workforce need and may be best suited for employer-sponsored earn-while-you-learn models.
5. **Create a DPHHS-led reimbursement workgroup.**
   - The workgroup should include DPHHS Medicaid, DLI, the Board of Nursing, employers, education programs, private payers, and legal/policy counsel.
   - Its charge should be to identify what is already billable, what could be recognized through Medicaid, what private payers may voluntarily support, and whether a state-plan, waiver, provider-manual, or rate-setting approach is feasible.
6. **Use other-state Medicaid trainee models cautiously.**
   - Washington peer specialist trainees, Missouri behavior technician transitions, and Virginia pharmacy intern/technician reimbursement provide structures to study.
   - They do not establish that nurse apprentices are automatically billable.

Public-Safety Guardrails

Any Montana nursing career-ladder pilot should include:

- **No independent practice expansion before licensure.**
- **No waiver of NCLEX requirements.**
- **Clear title rules:** apprentice titles must not imply full LPN or RN licensure.
- **Board-approved education alignment.**
- **Assigned RN or qualified LPN preceptors, depending on pathway stage.**
- **Scope-specific competency logs.**
- **Employer reporting of completion, retention, adverse events, and discipline.**
- **Sunset and evaluation requirements.**
- **Separate reimbursement feasibility review before any billing recommendation.**

Evaluation Metrics

Metric	Purpose
Number of CNA and LPN applicants	Measures demand
Rural participant percentage	Tests rural access
Completion rate	Measures feasibility
NCLEX-PN and NCLEX-RN pass rates	Protects licensure quality
LPN and RN license issuance rates	Measures endpoint success
Employer retention after licensure	Tests workforce value
Participant wage growth	Measures worker opportunity
Vacancy and turnover changes	Tests labor-market impact
Medicaid/private payer issues identified	Tests reimbursement feasibility
Adverse events or discipline	Tests patient safety

Draft Recommendation Language

The Healthcare Subcommittee recommends the DLI establish a **Nursing Career Ladder Pilot** consisting of two linked pathways: a **CNA-to-LPN pathway** and an **LPN-to-RN pathway**. The pilot should use existing statutory authority for apprenticeship licensure, preserve Board of Nursing oversight and NCLEX requirements, and permit limited apprentice registrations solely for supervision, title clarity, competency documentation, and workforce data. Apprentice registration should not authorize independent practice or direct billing.

The Healthcare Subcommittee further recommends establishment of a **DPHHS-led Apprentice Reimbursement Feasibility Workgroup** to evaluate whether any apprentice or trainee activities can be recognized through existing billing pathways, Medicaid state-plan or provider-manual changes, facility-rate or workforce-training support, or voluntary private-payer pilot agreements. The workgroup should use Medicaid trainee models from other states as reference points but should not assume that nurse apprentices are independently billable absent payer approval.

Bottom Line

The best nursing career-ladder option for Montana is a **linked, stackable, apprenticeship-supported pathway**: **CNA → Medication Aide II → advanced delegated-skill endorsements → LPN apprentice/bridge curriculum → NCLEX-PN → LPN → RN apprentice/bridge curriculum → NCLEX-RN → RN.**

Apprenticeship licensing can help Montana organize and safeguard that ladder. It can clarify titles, supervision, competency milestones, employer obligations, and Board oversight. It cannot, by itself, solve reimbursement. For Medicaid, Montana should study narrow supervised trainee or facility-rate models using Washington, Missouri, and Virginia as analogues. For private insurance, Montana should proceed by voluntary payer pilot only. The safest and most practical course is to create the nursing career ladders first, preserve existing licensure standards, and treat reimbursement as a separate, DPHHS-led feasibility project.