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## ***Past Event: 2026 APRN Roundtable - APRN Legislative Updates Video Transcript***

### **Event**

2026 APRN Roundtable

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### **Presenter**

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- [Nicole] Good morning, everybody. My name is Nicole Livanos, and I serve as the Director of Government Affairs for NCSBN. I'm really excited to be here today to provide a legislative update and talk about some of the national and state-level policies that are impacting APRNs. We're going to start off talking about the national policy environment, and specifically looking at the Rural Health Transformation Program, the Improving Care and Access to Nurses, or I CAN Act, and Title VIII reauthorization legislation.

So we'll start off by talking about the Rural Health Transformation Program. This program was enacted as part of HR1, or the One Big Beautiful Bill Act, a bill that contained tax and domestic spending priorities of the Trump administration. The program is a five-year, \$50 billion program with the purpose of expanding access to care and shoring up the healthcare workforce and delivery system in rural America.

The program is administered by CMS, and CMS provided guidance in their Notice of Funding opportunity for states and how they would be scored in terms of the funding that they would receive. Specifically, CMS said that they would score states based on their current policy environment, looking at what states have passed certain legislation that the administration has highlighted as being beneficial to promote access to care in rural areas.

Additionally, there are policy commitments where states would have an opportunity to commit to enacting some of those same policies and receive funding for their commitment to do so. So how does the Rural Health Transformation Program impact APRNs? There are two specific provisions that are of note.

First, in a state policy action, which is an action that a state can commit to, CMS noted that they would score states based on their nurse practitioner scope of practice environment. Specifically, the measurement used is the American Association of Nurse Practitioners state practice map. So that map that we all know, where green states are full practice authority, yellow are reduced, and red are

restricted, states would be evaluated based on where they were and awarded scoring or points based on that.

They would also have the opportunity to commit to enacting full practice authority and receive funding for those formal commitments. Another area, an initiative-based scoring element titled Population Health Clinical Infrastructure, states were scored based on information they provided to CMS about their healthcare landscape, including whether they had policies that expanded scope of practice for "mid-level" practitioners.

So we are now seeing how the Rural Health Transformation Program has impacted state policy in the 2026 legislative session. First, we spoke about those commitments that states could make to advance policies for nurse practitioner scope of practice.

CMS has announced that two states committed to enacting full practice authority, that would be New Jersey and Tennessee. Other states, like Missouri, included what we would term supportive language in their applications and materials that they sent to CMS. So in Missouri's case, the governor, in a letter of intent to apply to the Rural Health Transformation Program, noted that they were going to assess Missouri's scope of practice requirements for multiple professions.

Even in those states that have not formally committed to moving forward legislation and been awarded funds for that, we're still seeing this program being talked about across state legislatures. An example of that is in Florida, where Florida House Bill 693, the Big Beautiful Healthcare Frontier Act, looks to enact many of the rural healthcare programs and policies that the administration has stressed in the Rural Health Transformation Program.

This includes eliminating the limitation on APRNs who are practicing autonomously for only practicing in primary care. So if this bill is enacted into law, it would remove that primary care limitation, and all APRNs would be eligible to apply for autonomous practice in the state of Florida. We're also seeing this conversation around Rural Health Transformation Program and the Trump administration's supportive policy and putting funding behind removing barriers to APRN care as a way of strategically defending against bad legislation and state legislatures.

So we're seeing states that may have bills that would, for example, move a state backwards from full practice authority to reduced or restricted, or other policies that may restrict APRNs. And stakeholders and lawmakers are able to utilize the Rural Health Transformation Program as a way to say that we don't want to compromise any of our funding.

We don't want to do anything that could impact the dollars that are going to our rural areas. And that's been using in strategic defending against those policies. So next, we'll move to the Improving Care and Access to Nurses, or I CAN Act. This bill removes barriers to APRN care under both the Medicare and Medicaid program. For nurse practitioners, the bill does many things such as authorizing NPs to order cardiac and pulmonary rehab services, certify for diabetic shoes.

For CRNA, it importantly removes physician supervision requirements under the Medicare program. And for CNMs, it allows them to certify Medicare patients for home health, as well as issue prescriptions for durable medical equipment. This bill is introduced in both the House and the Senate, and we hope to see movement on this issue.

Next, the Title VIII Nursing Workforce Reauthorization Act, also introduced in both chambers of Congress. This bill would reauthorize Title VIII Nursing Workforce Development programs through fiscal year 2030. Importantly, the last reauthorization for this program was in 2020 as part of the COVID-19 CARES Act.

And the reauthorization has expired as of September 2025. So it's critically important that this area, which is the largest source of dedicated federal funding for nursing education and workforce development, be reauthorized. Specifically to APRNs, one of the programs that is critically important is the Advanced Nursing Education Workforce Program.

This is a program that supports primary care nurse practitioner and primary care clinical nurse specialist programs, as well as certified nurse midwives programs. So it's critical that this be reauthorized. Now that we've talked about the national landscape, let's turn to state legislation and see what's happening in the 2026 legislative session. We're going to be talking about three states, Utah, New Jersey, and Missouri, and covering areas such as RN experience requirements, talking about COVID-19 waivers, and also practice of medicine definitions, some trends that we're seeing across the states.

Turning to Utah, Utah is dealing with legislation that would require APRNs to have registered nursing experience requirements. Like many states, Utah has a process by which they periodically review regulatory boards and healthcare practitioner regulatory environments and practice.

In Utah, that's called the Office of Professional Licensure Review. And this year, they conducted a review of the Board of Nursing as well as nursing laws across the state. A recommendation from the office to the legislature was that the legislature adopt RN experience hour requirements for certified nurse practitioners as a licensure requirement.

This was codified into Senate Bill 31. And I'm highlighting that this is the bill as introduced. And as introduced, the bill requires applicants for certified nurse practitioner licensure to have 6,000 hours of RN clinical experience.

So that is a requirement they must have in order to be licensed as a CNP in Utah. Additionally, it reduced the physician assistant transition to practice hours for independent practice from 10,000 to 8,500. And lastly, it granted CRNAs prescriptive authority. Again, another recommendation coming out of that Office of Professional Licensure Review.

You'll have a panel talking about this issue later so I'm not going to get into the specifics. But just want to highlight that Utah, just like Alabama, just like Wisconsin, are all looking at this RN experience hour requirement, whether it be through regulation, through statute, as a licensure requirement, or in the case of Wisconsin, as a requirement in order to have independent practice.

Next, we're going to be talking about New Jersey, and we're going to be talking about COVID-19 era waivers, which may make you think that we are recording this way back in 2020-2021. But no, it is 2026. And we are still talking about COVID-19 waivers, waivers that governors or legislators issued in order to provide for maximum flexibility during the public health emergency.

New Jersey, just like many states, issued executive orders in both March and April of 2020, that first declared a state of emergency in the state and then later provided for a waiver for APRN joint protocol agreements or collaborative practice agreements.

In January 16, 2026, many of us learned that those waivers were still in place in New Jersey. So despite a lot of the COVID-19 era policies and other jurisdictions expiring, or going by the wayside, New Jersey was still operating under this waiver of the joint protocol agreements.

And so when Governor Phil Murphy on his way out of office, issued Executive Order 415, that terminated the state of emergency in New Jersey. And specifically, the termination date was 30 days later, or February 16, 2026, at precisely 5pm. What this meant is that APRNs who were not subject to these joint protocol agreement requirements suddenly had 30 days to get back into or, for the very first time, enter into a joint protocol agreement with a physician.

Governor Sherrill, who's a new governor in New Jersey, extended that waiver through April 2, 2026, to allow APRNs more time and to prevent or try and limit and mitigate the number of individuals and patients who may not be able to receive care as APRNs were looking to secure those joint protocol agreements.

So just to step back in those COVID-19 era waivers, these could have been executive, legislative or regulatory waivers, and they really were operating on a broad spectrum. Some specifically waived the collaborative practice agreements for certain roles or certain settings or for certain patients, such as individuals that were responding directly to patients with COVID-19.

Whereas others, like in New Jersey, waived those restrictions completely in order to provide for maximum flexibility, and knowing that there needed to be provisions in place that would allow for maximum access to care for patients. I want to highlight a Journal of Nursing Regulation study that was conducted, and it was in two parts. The first was an evaluation of disciplinary records across 27 states.

And notably, that review found no evidence of an uptick in APRN discipline cases. So even though those requirements were waived during that time, there was no significant difference in APRNs being disciplined. Again, evidence of the fact that these restrictions are not tied to patient safety.

There was also a component where over 16,500 APRNs were surveyed to see what the impact of the waiver was on their practice. And notably, the study found that APRNs practicing in private outpatient clinics, in rural areas, and in healthcare provider shortage areas, were more likely to report a positive effect of the practice waiver.

That is critical. So with all that in mind, that brings us to the New Jersey legislative session, where there are two bills, one in the House and one in the Senate, that, as introduced, would eliminate those joint protocol agreements after 24 months, or 2,400 hours. Additionally, it allows that transition to practice period, where an APRN needs to be in a joint protocol agreement to be able to be done with a physician or an APRN collaborator.

So expanding the providers who can serve as that collaborator. The bill has had a hearing in February in a Senate committee. And to say that there's urgency in New Jersey around this issue is the understatement of the legislative session. And you also have the Rural Health Transformation Program funds, because remember, New Jersey committed to full practice authority.

So there is a time clock on that. And if New Jersey were to fail to pass legislation to enact full practice authority by the end of the 2027 session, they are at risk of having those funds that were awarded to them for this commitment, clawed back by CMS. So a lot of eyes are on New Jersey right now.

Now we're going to turn to Missouri, and we're going to talk about bills, like a bill in Missouri that would look to define the practice of medicine and what impact that might have on APRN care. To step back and set the stage for the 2026 legislative session, there are several pieces of legislation moving in Missouri.

One group of legislation is being advanced by the Better Access Better Care Coalition. And that includes legislation that would eliminate Missouri's collaborative practice agreement requirements for certified nurse practitioners, certified nurse midwives, and clinical nurse specialists. Additionally, there is CRNA legislation that is running at the same time. This bill would enable CRNAs to order, select, and administer controlled substances schedules II through V for and during anesthesia care.

Both bills have had hearings in March 2026 in the Senate Emerging Issues and Professional Registration Committee. So why are we talking about retaliatory legislation and the definition of practice of medicine when we're talking about Missouri? Because oftentimes, as many of you will know, states introduce legislation that I'm dubbing retaliatory legislation that looks to perhaps walk back current practice environments that have removed barriers to APRNs and other providers providing care, or states like Missouri and New Jersey that we just discussed are looking actively to remove these barriers.

The retaliatory legislation comes in a lot of different flavors, many of which will be familiar to you. The first is title protection. Many of you have seen bills that restrict individuals who have earned doctoral degrees from utilizing the term doctor when they are caring for patients and introducing themselves to those patients.

There are others that prevent individuals from using specialty words or specialty titles. Those bills we generally refer to as the ologist bills, they may prevent APRNs or other providers from using words such as anesthesiologist or dermatologist.

We also see bills and more frequently, conversations around shifting regulatory authority over APRNs to the medical board or a physician-controlled regulatory body. Certainly, those things have both appeared in Missouri in the last couple of sessions and the discussions around those issues continue.

But what we've seen in Missouri this year that I want to highlight is a bill that would define the practice of medicine. This bill is introduced by Missouri Senator Justin Brown, who is the chair of that Senate committee that we just talked about the APRN bills got a hearing in. He filed Senate Bill 1672. So I want to draw your attention specifically to section two in Senate Bill 1672.

The first part that's a little grayed out on your screen that we could see across any medical practice act in the country. It's a provision that states "Nothing contained in this section shall prohibit a licensed professional from performing some or all of the activities that may fall within the practice of medicine, but only so long as the licensed professional is acting within and not beyond the scope of his or her statutory authority."

That provision right there recognizes that there's overlapping scope between health care professionals. And the important point is that they're not practicing beyond their scope of practice that's laid out in statute. However, the bill does not stop there. It continues, "...and only so long as the physician remains actively involved in the practice of medicine for each patient, and remains the primary and responsible party for the examination, evaluation, diagnosis, and determination of appropriate treatment or surgery."

So let's step back outside of Missouri, thinking about how health care is delivered across the country. This would be severely disrupted disruptive to how care is delivered today. This says that any care that is not provided where a physician remains actively involved for each patient, and is the primary and responsible party for the examination, evaluation, diagnosis, or determination of appropriate treatment or surgery would be violating the law.

So this provision would really impact APRN care in the state and other providers that are practicing without these conditions having been met. So it's an important bill to watch. And again, I would categorize the bill under that issue area of retaliatory legislation that so often we see when a state also has legislation looking to remove or reduce barriers.

So that was just a quick overview of some of the issues that are at the national and state level that impact APRN practice, regulation and access to care for patients. We saw themes of improving access to care in rural and underserved areas, such as through the Rural Health Transformation Program, which will continue to be an issue for states as they move through the five-year program.

Additionally, we know there are many bills out there that are looking to enact full practice authority for APRNs and remove restrictive barriers that will allow APRNs to practice to the top of their license. So we're right in the middle of many states' legislative sessions, and Congress also continues to be in session.

So it'll be really important to watch what happens. And now I'm excited to move into the Q&A and answer some of the questions that you may have.

- [Emily] Hi, Nicole, welcome. Thank you for joining us today and taking the time.

- Thank you, Emily. I'm so happy to be here.

- So as we know, the legislative process moves quickly. Are there any updates or movements on some of the bills that you had mentioned?

- Yeah, absolutely. The state legislative sessions, they really do move fast. So I do want to provide a few quick but key updates to what was in the presentation. So first, an update on Utah Senate Bill 31. As mentioned, the bill as introduced provided for prescriptive authority for CRNAs and also would have mandated a 6,000-hour RN experience requirement for NP licensure.

During the legislative process, the bill took on many amendments and some related to those RN experience requirements. First, the hours were reduced from 6,000 hours to 2,000 hours. But then a subsequent amendment passed, which removed those hours entirely. I am happy to report that the CRNA prescriptive authority provisions did make it all the way to enactment.

So, definitely a win for access to anesthesia care for patients and for our Utah CRNA colleagues and advocates. Next, an update in New Jersey, where really advocates had to keep their heads on a swivel this session. You had the expiration of a public health emergency that waived joint protocol agreements for APRNs, both an assembly and a Senate bill making its way through the legislative process.

And oh, that Rural Health Transformation Program thing, where the state has committed to enacting full practice authority by December 31, 2027. And if not, has the potential to lose out on those federal

dollars. So where are we today? Well, the PHA waiver fully expired on April 2. So joint protocol agreements are back in New Jersey after nearly a six-year hiatus.

Governor Mickey Sherrill has signed legislation that provides for a pathway for some APRNs to have independent practice and retire those joint protocol agreements for good. However, these provisions apply to APRNs that only meet certain requirements, which includes 5,000 hours of APRN experience, what they have to be certified in certain population foci, practice within primary care or behavioral health care, and not practice in areas that include elective aesthetics and cosmetic services.

So it's definitely going to be important to keep watching this legislation as it moves to the all-important implementation phase, and see what impact this may have on removing barriers to patient care in New Jersey. Last but not least, some good news out of Missouri. I'm excited to share that in addition to the CRNS legislation advancing out of that Senate emerging issues committee, the independent practice bill for the other three roles also advanced out of that committee.

So as of today, also that practice of medicine bill, that so-called retaliatory legislation I spoke about, has not received a hearing. So knock on wood, that's a good thing, and only a few short weeks left in the Missouri legislative session.

- Well, I'm glad that's on a positive note. So you also mentioned the reauthorization for Title VIII programs had expired in September. So are there any updates on the status of those critical nursing workforce development programs today?

- Yeah, so I wish that I could report to you here live that Title VIII programs have been reauthorized, but they do remain unauthorized. That authorization did lapse in September of 2025 and continues today. However, the all-important appropriation process for fiscal year 2027 is in full swing.

And so debate about the funding for these programs is continuing now and is up for debate. President Trump's FY 27 budget request proposes a nearly 70% reduction in Title VIII funding. That's \$212.8 million reduction.

And it does so by proposing the elimination of all Title VIII programs, except for the Nurse Corps Scholarship and Loan Repayment Program. The Nursing Community Coalition is hard at work and is urging Congress to fund all Title VIII programs for FY 27 appropriations and are requesting a funding level higher than previous requests, which really reflect conversations with bipartisan nursing champions who share the concerns about ongoing workforce challenges and the sustainability of nursing education and faculty pathways.

So the crucial fight for the Title VIII program continues both in that reauthorization as well as appropriations venues.

- So, along those same lines with Title VIII, it seems that that was only for APRNs working in primary care. And as we all know, there's a lot of APRNs that are working in acute care roles along the neonatal, pediatric, adult gero tracks. So, and these are all facing significant workforce deficits.

So how can we change that wording so that all APRN delineations and populations are represented there?

- So Emily, are you referring to the New Jersey legislation that limited those population foci?

- Yes. My apologies.

- Yeah, so yeah, absolutely. Look, I think that this was a huge step and an incremental progress in aligning New Jersey with the APRN consensus model. But certainly, I think advocates on the ground would agree there's still work to be done. And so some states strategically take these incremental steps. They are hard-fought legislative battles, but there clearly is work to do.

And so an important thing to watch is going to be not only about how the bill moves through the implementation process, but/or not only what impact the bill will have on patient care in New Jersey. And hopefully, certainly, you know, there will be positive impact for patients by removing these barriers for some APRNs.

But it'll be important to watch what are the gaps? What are we missing here? What is the uncertainty that might have been created by legislation like this? Oftentimes, when you get into that nitty gritty, and you're trying to regulate at such a hyper-specific level, such as the type of care provided or a type of certification someone holds, we know that that can create barriers and regulatory barriers and barriers to care.

So definitely that is important as well to watch for in the future. And I, if I had a crystal ball, I'd say that we should expect New Jersey to introduce legislation in the future. And if they want to comply with the Rural Health Transformation Program commitment, the state will need to do so for nurse practitioners by December 31, 2027.

- So one last question. Another issue that lawmakers are dealing with is that of the interstate compacts. I know we at NCSBN do track these very closely. Are there any updates for our audience members that they should know regarding the APRN compact in particular?

- Yeah, that's a great question. Thank you, Emily. So definitely. A big update is that the NCSBN Board of Directors has charged NCSBN staff to work with boards of nursing to redesign the APRN compact. That process is underway now, and we're very excited about the critical and crucial work ahead.

The goal remains the same as it always has. It's to create an interstate compact designed by nursing regulators that will provide for the provision of safe and quality APRN care for patients and important licensure mobility pathways for APRNs. So really excited about that work, and I'm sure that we'll be reporting updates to this group as we move along.

- Absolutely. Well, thank you so much for your time, Nicole. We really appreciate you being here and providing all of these updates. We are going to move forward into a break right now, and we will come back and return at 10:40 Central Time to talk about the evolution of the APRN consensus model. Thank you.