Transition-to-Practice Repeal Act
HF1794 (Virnig) / SF1794 (Kupec)

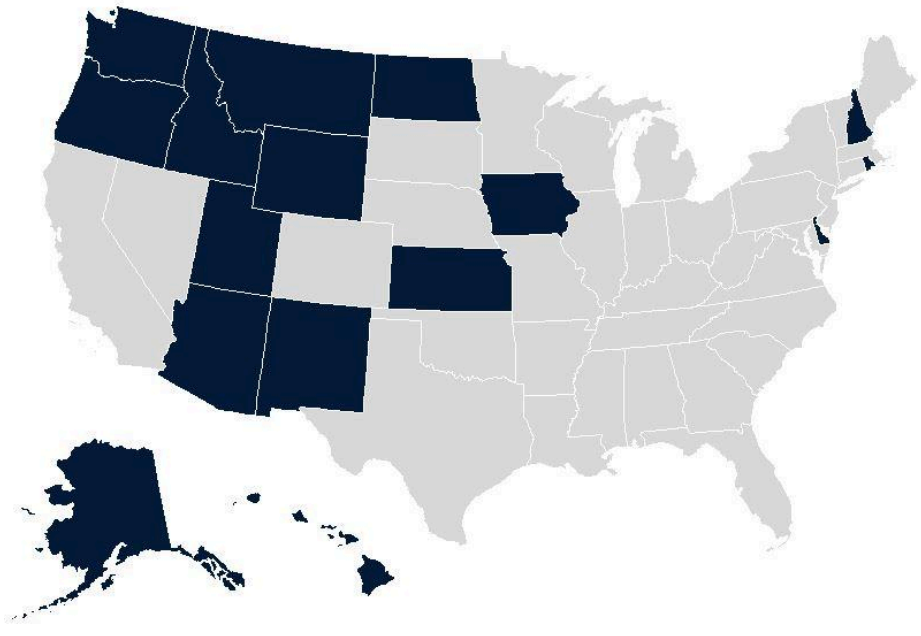
Current MN Statute Harms APRN-Led Clinics and Access

The growth of Advanced Practice Registered Nurse (APRN) led clinics is constrained by an outdated and burdensome "transition-to-practice" requirement in Minnesota statute. APRNs in Minnesota have full practice authority, however Minnesota Statute 148.211 requires nurse practitioner (NP) and clinical nurse specialist (CNS) graduates to complete their first 2,080 hours in a setting that also employs a physician. This requirement:

- Bars APRN-led clinics from hiring new graduates, even when those graduates trained in the clinic and are prepared to continue serving that patient population, unless the clinic is able to shoulder the cost of a contract with a physician.
- Restricts employment opportunities for new NPs and CNSs, who cannot practice in APRN-led settings without a physician on staff.
- Drives workforce loss to neighboring states, such as Iowa and North Dakota, that do not impose similar barriers.
- Distorts market competition, favoring large health systems that can easily meet the statutory requirements over small, community-based practices.
- Doesn't add value or address a problem. APRN's education and licensure requirements prepare them for practice, as evidenced by research showing APRNs have excellent outcomes in terms of health markers, chronic disease control, length of hospital stay, readmissions, patient satisfaction and more.[1]

HF1794 / SF1794 Aims to Remove this Unnecessary Regulatory Burden

The Transition to Practice Repeal Act eliminates this statutory barrier to practice, expanding access to mental health and primary care services, particularly in Greater Minnesota. Enacting this legislation would align Minnesota with 16 other states and DC that have full practice authority like MN but do not require a transition-to-practice period. (See map below.)



MINNESOTA APRN COALITION

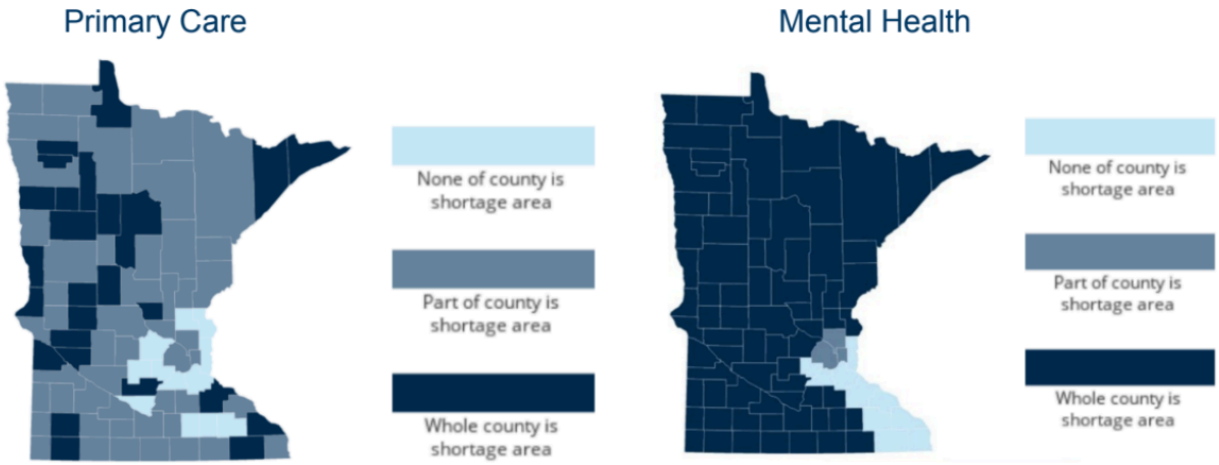
We Care for You

MN Counties Face Shortages of Primary & Mental Health Care Providers

These workforce shortages undermine health outcomes statewide by making it harder to secure timely appointments, increasing travel distances, and raising the risk of delayed or foregone care.

- 30% of counties have a *shortage* of primary care providers;
- 56% of counties have a *partial shortage* of primary care providers;
- 80% of counties qualify as mental health shortage area

Health Professional Shortage Areas in MN
Source: Health Resources and Service Administration, U.S. HHS May 2023



APRNs and APRN-Led Clinics Provide Essential Services In Critical Gap Areas

- There are an estimated 12,000-13,000 APRNs in MN, including certified registered nurse anesthetists (CRNAs), certified nurse midwives (CNMs), certified nurse specialists (CNSs), and nurse practitioners (NPs).
- Since 2015, APRNs have launched APRN-led clinics, a model expanding primary care and mental health services across MN. In a 2017-2018 MDH workforce survey, nearly 425 APRNs in Minnesota reported owning or co-owning a private practice, with 25% located in rural Minnesota.[2]
- In the same workforce survey, over 500 APRNs in Minnesota identified mental health as their specialty.[2]

[1] https://www.aanp.org/advocacy/advocacy-resource/position-statements/quality-of-nurse-practitioner-practice

[2] https://www.health.state.mn.us/data/workforce/nurse/docs/2019aprnb.pdf

Committee on Health Finance and Policy
Minnesota House of Representatives
658 Cedar St.
Saint Paul, MN 55155

March 10, 2026

Re: HF 1794

Dear members of the Committee on Health Finance and Policy,

The American Association of Nurse Practitioners® (AANP) appreciates the opportunity to submit written comments in on HF 1794 as introduced before the Committee on Health Finance and Policy in the hearing on Wednesday, March 11, 2026. On behalf of our Minnesota nurse practitioner (NP) members and the patients they serve, AANP supports HF 1794.

Minnesota is struggling to meet the growing need for access to timely, high-quality care. Simultaneously, the state faces persistent health care workforce shortages and rising health care costs. Exacerbating those challenges is an outdated law that limits the NP workforce and makes it harder for the state to recruit and retain nurse practitioners.

HF 1794 offers a no-cost, no-delay solution to help grow Minnesota's health care workforce. By retiring unnecessary regulations, this legislation would make an immediate and beneficial difference for communities that need improved access to quality, affordable health care. There is compelling evidence to support this legislation without amendments.

NPs are Qualified Providers with a Track Record of Meeting Needs

NPs have been providing primary, acute, mental and specialty care to millions of patients across the lifespan for more than half a century. NPs evaluate patients, diagnose, write prescriptions, and provide whole-person care to patients in nearly one billion patient visits per year. They complete six years of undergraduate and graduate education that includes embedded hands-on supervised clinical rotations. NPs are additionally required to complete continuing education requirements and maintain national board certification for licensure.

Minnesotans have grown to appreciate and rely on NP care. Nurse practitioners provide a substantial and growing portion of the high-quality[1], cost-effective[2] care that our communities require. NPs the largest and fastest growing Medicare designated provider specialty.[3] Approximately 42% of Medicare patients receive billable services from a nurse practitioner[4], and approximately 80% of NPs are seeing Medicare and Medicaid patients.[5]

[1] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.
[2] https://storage.aanp.org/www/documents/advocacy/position-papers/Nurse_Practitioner_Cost_Effectiveness.pdf.
[3] data.cms.gov MDCR Providers 6 Calendar Years 2017-2021.
[4] Ibid.
[5] https://storage.aanp.org/www/documents/NP_Infographic_111122.pdf

NPs also provide a substantial portion of health care in rural areas and areas of lower socioeconomic and health status.[6,7,8] NPs are also significantly more likely than primary care physicians to care for vulnerable populations; including women, indigenous and Native Americans, the poor and uninsured, people on Medicaid, those living in rural areas, and dual-eligibles are all more likely to receive primary care from NPs than from physicians.[9]

Minnesota is at a competitive disadvantage and falling behind other states
Nineteen jurisdictions—16 states, DC, and two territories—have already retired laws mandating post-licensure collaborative agreements of nurse practitioners. Many of these jurisdictions have had this regulatory model in place for several decades and lead the nation in advancing patient-centered health care and innovative systems of care delivery.

Importantly, no state that has adopted legislation like HF 1794 has ever returned to a more restrictive model, and these states have a competitive advantage in recruiting and retaining nurse practitioners. In fact, some states have specifically noted that maintaining beneficial licensure laws is a successful strategy for recruiting NPs into their workforce from more restrictive states.[10]

Evidence Supports Retiring Outdated Law
There is no evidence that these mandated contract periods are necessary or beneficial for patients or providers. There is a growing body of research on health care quality and cost outcomes in states that have retired government-mandated post-licensure agreement requirements. These studies found that states without this barrier have maintained quality health care outcomes, have lower hospital admissions rates, perform better on some key health care measures, and have lower health care costs than in those that have not yet modernized their laws. Additionally, a recently published peer-reviewed analysis of adverse action reports and malpractice payments rates found no statistical difference between states with requirements like Minnesota's and states that had retired them.[11]

On behalf of the American Association of Nurse Practitioners and our Minnesota membership, we urge support of HF 1794.

Sincerely,

Valerie Fuller, PhD, DNP, AGACNP-BC, FNP-BC, FAAN, FNAP, FAANP
President, American Association of Nurse Practitioners

[6] Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (2018). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. Journal of General Internal Medicine, 4–6. https://doi.org/10.1007/s11606-017-4287-4.
[7] Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016. Journal of the American Medical Association, 321(1), 102–105.
[8] Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. Medical Care Research and Review, Epub ahead. https://doi.org/10.1177/1077558718793070
[9] Buerhaus, P. (2018). *Nurse Practitioners: A Solution to America's Primary Care Crisis*. American Enterprise Institute. Retrieved April11, 2025 from https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/
[10] Tabor J.A., Jennings N., Kohler L, Degan B, Derksen D, Eng HJ, Campos-Outcalt D, Derksen D. AzCRH 2015 Supply and Demand Study of Arizona Health Practitioners and Professionals. Arizona Area Health Education Centers and Center for Rural Health, University of Arizona, Tucson, 2016; https://crh.arizona.edu/sites/default/files/2022-04/022616_AzCRH_Supply_and_Demand_Report.pdf
[11] Dillon D. Do transition to practice hour requirements make a difference in adverse action and medical malpractice payment reports: An analysis from the National Practitioner Data Bank. (2024) JAANP DOI: 10.1097/JXX.0000000001091

Good afternoon Committee,

My name is Debbi Lindgren-Clendenen, and I am a practicing dual certified adult and gerontological nurse practitioner and a resident of the city of Minneapolis for the past 40 years. Today I am writing in support of HF 1794 on behalf of myself.

I am a lifelong Minnesotan, born, raised and educated all in this great state of 10,000 lakes. I have been in practice in Minnesota for nineteen years; working in the urban, rural and suburban settings and partnering with Minnesotans in optimizing their healthcare. I currently practice at a non-profit entity called AAGING HEALTHY LLC. AAGING HEALTHY, LLC partners with patients in optimizing their healthcare in assisting with healthcare navigation. During my career, I have seen Minnesota NPs step up to become the backbone of healthcare in our state, caring for some of the most underserved communities, even providing specialty cardiology care rurally to these patients via telehealth well before and during SARS CoV2 pandemic.

Minnesota state law authorizes NPs to evaluate patients, diagnose, write prescriptions and provide whole-person care to patients across the state. They complete six years of undergraduate and graduate education that includes embedded hands-on supervised clinical rotations.

As members of this Committee, you know that our state faces unique challenges arising from our aging population, regional differences in access, provider shortages, and high rates of chronic disease. To meet these challenges Minnesota needs to do better. And that is what HF 1794 is designed to do.

The issue is that there is no evidence that these mandated contracts are necessary. And it's creating challenges to moving our state forward.

HF 1794 offers a solution that helps and requires no additional state funding. It's a solution that 16 states, DC and 2 US territories have already enacted.

This legislation will not change the scope of practice and NPs would still be required to complete nationally accredited NP graduate programs that include advanced didactic and clinical hands-on supervised rotations, and NPs must pass national board certification exams.

HF 1794 is the right step for our state and I urge you to vote in support of HF 1794.

Thank you.

Respectfully,

Deb LC aka Debbi Lindgren-Clendenen RN, MN, APRN, CNP, GNP-BC, AGPCNP-BC, CPAHA, FAANP

MINNESOTA MEDICAL ASSOCIATION

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March 10, 2026

Dear Members of the House Health Finance and Policy Committee,

On behalf of the Minnesota Medical Association (MMA), I write to respectfully oppose HF 1794, which would remove postgraduate collaborative practice requirements for advanced practice registered nurses (APRNs).

In Minnesota, a nurse practitioner or clinical nurse specialist who qualifies for licensure as an APRN must practice for at least 2,080 hours under a collaborative agreement, in which they work alongside a physician to provide care at a hospital or integrated clinical setting. This requirement facilitates structured mentorship, patient safety, and an introduction to APRNs' roles and scope within physician-led healthcare teams.

Minnesota physicians value the importance of APRNs in our healthcare system. However, to remove postgraduate collaborative practice requirements is to threaten the preparedness of new APRNs and the quality of care rendered to the patients they serve.

This bill may also undermine affordability of care. According to the American Medical Association, studies have shown that, when APRNs practice outside of physician-led care teams, healthcare costs rise because they order more diagnostic imaging tests and prescribe more antibiotics and opioids than physicians.

Minnesota has long supported collaborative, physician-led care models that prioritize patient safety and quality outcomes. We believe that removing the oversight provided by postgraduate collaborative practice agreements will not only jeopardize the quality of care but also compromise patient safety. For these reasons, the MMA urges you to oppose HF 1794.

Sincerely,

Lisa R. Mattson MD

Lisa Mattson, MD
President, Minnesota Medical Association