ata ACTION
Telehealth Policy to Transform Healthcare

March 16, 2026

The Honorable Jeff Backer
Co-Chair, Health Finance and Policy Committee
Minnesota House of Representatives
100 Rev Dr Martin Luther King Jr Blvd
St. Paul, MN 55155

The Honorable Robert Bierman
Co-Chair, Health Finance and Policy Committee
Minnesota House of Representatives
100 Rev Dr Martin Luther King Jr Blvd
St. Paul, MN 55155

RE: ATA ACTION COMMENTS ON HF 3893

Dear Co-Chair Backer, Co-Chair Bierman, and members of the Health Finance and Policy Committee,

On behalf of ATA Action, I am writing to share our association's perspective on H.F. 3893, which would regulate the use of artificial intelligence in psychotherapy services. Our organization appreciates the Legislature's focus on patient protection and the quality of mental health services, and we are broadly supportive of the intent of this legislation. However, we are concerned that, as written, the bill could unintentionally restrict licensed clinicians from using beneficial AI tools consistent with their scope of practice, cause confusion for providers and patients due to overly broad definitions, and fails to account for FDA-cleared products or to require informed patient consent. We urge the Committee to consider the amendments described below before advancing H.F. 3893.

ATA Action is the affiliated policy and legislative advocacy arm of the American Telemedicine Association. ATA Action is the leading advocacy organization dedicated to advancing policy and accelerating the adoption of technology-enabled healthcare. Working collaboratively with federal and state legislators and policymakers, our organization drives industry momentum by influencing legislative and regulatory developments in telehealth, virtual care, remote patient monitoring, artificial intelligence in health, health data privacy, private sector healthcare investment, and more. We represent a diverse membership – including hospital systems, technology companies, professional associations, direct-to-consumer digital health providers, payers, pharmaceutical manufacturers, digital therapeutics developers, and remote monitoring organizations.

ATA Action has followed and engaged in the development of state policies regarding the use of AI in mental health care, including the recently enacted Illinois and Nevada AI mental health frameworks – which appear to have served as the inspiration for H.F. 3893. Both states enacted their laws with significant flaws in place, over our opposition, including failures to consider FDA-cleared products, overly broad definitions, and restrictions that limit licensed clinicians from using AI tools consistent with their scope of practice and the standard of care. Unfortunately, H.F. 3893 appears to have imported many of these issues, and we believe the following amendments are necessary if this bill is to be advanced.

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The Definition of "Therapeutic Communication" Is Overly Broad

The definition of "therapeutic communication" in Subdivision 1(h) captures everyday, non-clinical speech that unlicensed persons, health coaches, community health workers, and peer supporters routinely use in communications with individuals about their mental or emotional health. The opening clause extends to any interaction "intended to … address an individual's mental, emotional, or behavioral health concerns" – a standard broad enough to encompass general wellness guidance and supportive conversation that have never been considered the exclusive domain of licensed clinicians. Similarly, several of the enumerated examples, including item (2) ("providing guidance, therapeutic strategies, or interventions designed to achieve mental health outcomes") and item (5) ("offering behavioral feedback intended to promote psychological growth or address mental health conditions"), are broad enough to sweep in coaching, wellness guidance, and other non-clinical services. Item (3) ("offering emotional support … in response to psychological or emotional distress") captures everyday empathic conversation rather than the specific, clinically significant interactions it should target.

We believe the definition should be carefully narrowed to capture only what is truly clinical, therapeutic speech delivered by a licensed professional in a therapeutic context. We recommend removing "or address" from the opening clause, revising item (1) to capture direct interactions that constitute the delivery of therapy or psychotherapy services rather than any exchange involving understanding or reflecting a client's thoughts, deleting items (2) and (5), and narrowing item (3) to "suicidal or self-harm ideation" rather than "psychological or emotional distress." We also recommend adding a negative definition clarifying that "therapeutic communication" does not include general wellness education, instruction, or guidance intended to promote overall health and well-being rather than to diagnose or treat a specific mental, emotional, or behavioral health concern.

The Definition of "Therapy or Psychotherapy Services" Should Be Narrowed

The definition of "therapy or psychotherapy services" in Subdivision 1(i) includes services that "improve" an individual's mental health or behavioral health – a standard so broad it could capture a wide range of resources, products, or services not currently provided by licensed professionals. The relevant mental health professional associations do not define therapy or psychotherapy so expansively. Given that the bill's significant requirements and prohibitions flow from this definition, we believe it should be narrowed to services provided to diagnose or treat.

The Requirement to Anonymize Patient Data for Progress Tracking Is Counterproductive

Subdivision 1(b)(4) limits AI-assisted analysis of client data to "anonymized data" for the purpose of tracking client progress or identifying trends. Tracking an individual patient's progress over time necessarily requires that the data be linked to that patient – anonymizing it removes the very information that makes patient-level progress tracking clinically meaningful. Existing HIPAA and state confidentiality frameworks provide robust protections for identifiable patient data without this additional restriction. We recommend removing the word "anonymized."

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The Permitted Use Framework Should Allow Clinicians to Use AI Consistent With Their Scope of Practice

Subdivision 3 authorizes licensed professionals to use AI only to assist in providing "administrative or supplementary support." While we appreciate that Minnesota's bill combines these categories – which is an improvement over bills in some other states that limited permitted use to administrative support only – we are concerned that the framework still does not clearly permit licensed clinicians to use AI tools in their clinical practice consistent with their scope of practice and the standard of care. Clinicians should be able to use AI as a clinical tool under their professional judgment and oversight, not merely for background support functions. We recommend clarifying that licensed professionals may use AI systems consistent with their license, the standard of care, and appropriate professional oversight.

The Bill Fails to Account for FDA-Cleared Products

As currently drafted, H.F. 3893 does not distinguish between FDA-cleared AI products and unregulated consumer applications, treating all products the same. We believe this is potentially harmful to patient care and inconsistent with sound regulatory policy.

FDA-regulated digital therapeutics and AI tools are held to rigorous standards, including quality management systems, cybersecurity requirements, and mandatory adverse event reporting, ensuring both safety and efficacy. Our organization represents Digital Therapeutics – clinically validated, FDA-regulated Software as a Medical Device products that incorporate artificial intelligence and other technologies into treatments delivered to patients through phones, tablets, computers, and VR headsets. The FDA cleared its first prescription digital therapeutic in 2017 and has since approved more than 20 through this rigorous review process under both the Biden and Trump administrations.

These products undergo clinical validation, are subject to pre- and post-market oversight, and involve regulated healthcare practitioners as gatekeepers, protecting patients throughout the care process. In contrast, unregulated mobile health apps operate without these safeguards, rely only on general consumer protections, and may compromise patient data while making unproven health claims. Maintaining the distinction between regulated and unregulated products is essential to protect patients while allowing safe, evidence-based digital interventions to thrive. Indeed, given the existing federal oversight, Colorado's AI Act – the country's first comprehensive AI law – exempts high-risk AI systems already approved, authorized, or certified by the FDA. We urge the Committee to add a similar exemption to Subdivision 5.

Thank you for the opportunity to comment on H.F. 3893. We urge the Committee to consider our feedback before advancing this bill, with the goal of striking the best balance between patient safety, clinician flexibility, and regulatory clarity. If you have any questions or would like to discuss the telehealth industry's perspective further, please contact me at hyoung@ataaction.org.

Kind regards,

Hunter Young

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