ata ACTION
Telehealth Policy to Transform Healthcare

March 13, 2026

The Honorable Tou Xiong
Chair, Senate State and Local Government Committee
Minnesota Legislature
3203 Minnesota Senate Bldg.
St. Paul, MN 55155

RE: ATA ACTION CONCERNS REGARDING SF 2939

Dear Chair Xiong and Members of the State and Local Government Committee,

On behalf of ATA Action, I am writing to express serious concerns about Senate File 2939 as recently amended by the Health and Human Services Committee and the significant unintended consequences that will result without additional discussion and the further refinement that this legislation warrants.

ATA Action, the American Telemedicine Association's affiliated trade association focused on advocacy, advances policy to ensure all individuals have permanent access to telehealth services across the care continuum. ATA Action supports the enactment of state and federal telehealth policies to secure telehealth access for all Americans, including those in rural and underserved communities. ATA Action recognizes that telehealth and virtual care have the potential to truly transform the health care delivery system – by improving patient outcomes, enhancing safety and effectiveness of care, addressing health disparities, and reducing costs – if only allowed to flourish.

Our organization supports transparency in the provision of healthcare and is in strong support of the notion that nothing should interfere with physicians' and other healthcare providers' clinical decisions on patient care. However, if SF 2939 is enacted as currently drafted there will be significant unintended consequences that could severely restrict patient access to care and stifle continued investment in Minnesota, to the detriment of Minnesota patients. This legislation appears to be influenced by National Academy for State Health Policy's (NASHP's) "Model Act for State Oversight of Proposed Health Care Mergers," a model policy which did not include any telehealth providers in its development and as a result fails to consider telehealth entities operating across state lines.

Many national telehealth medical practices serving Minnesota patients – similar to those that deliver care in-person – operate using a model where non-physicians (or "lay entities") provide administrative support and/or investment capital to a provider or group practice, while the provider controls all clinical decisions, protocols and patient care. This model allows state-licensed telehealth providers to maximize their time spent on patient care and contract out nonmedical duties, including billing, credentialing and contracting, to other personnel. Importantly, this structure has provided a way for innovative technologies and medical providers in Minnesota to access needed financing and develop new care delivery models, including emerging telehealth companies capable of reaching stigmatized populations in Minnesota and throughout the country.

ATA Action has significant concern that SF 2939 would unnecessarily jeopardize this long-established model and disrupt access to care for the many Minnesotans currently being served by telehealth entities.

ATA ACTION
601 13th St NW, 12th Floor Washington, DC 20005
Info@ataaction.org

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The legislation proposes several sweeping new mandates – not grounded in current precedent or existing policy – that would upend and prohibit how currently compliant telehealth provider entities contract with lay entities for business operations, non-physician expertise, and investment.

First, ATA Action has significant concerns regarding how the legislation (Section 319B.41 Subd. 3.(b)(1)) bans *without exception* any shareholder, director, officer or partner of a medical practice (often referred to as a Physician Corporation or PC) from also being employed by or holding any shares in the contracted management services organization (MSO). This is a severe restriction and will have a disproportionate impact on emerging and innovative entities, where the MSO and PC are built together from the ground up and capitalize upon synergies that would not be possible if such a restriction were put in place.

Many ATA and ATA Action member entities currently have a physician who is a director or shareholder in a professional medical corporation who also serves as a clinical director or holds a management role in an MSO (the MSO in turn manages the administrative functions and owns the technology powering the telehealth visit). These clinical directors, who bring a wealth of practice experience and a day-to-day perspective of the professional medical corporation, are crucial for ensuring that MSOs understand the effects its business decisions can have on the patients who seek care through their platforms as well as the needs of providers who use the platform to deliver high quality services. Rather than physicians being totally detached and isolated from the MSO infrastructure supporting and helping to grow the medical practice, many telehealth entities have found that having a physician affiliated with both the medical corporation and the MSO improves decision making, provides direct and open lines of communication, and leads to heightened patient and provider satisfaction. In effect, this beneficial integration would be eliminated by the proposed legislation.

Unfortunately, by eliminating the ability for Minnesota licensed practitioners to continue as both practitioners and as in-house advisors to their contracted MSOs or telehealth platforms, the legislation would prohibit, or at best significantly frustrate, the ability for these MSOs to include this extensive practical knowledge base at the boardroom table.

It is also unclear how the broad mandates in Section 319B.41 Subd. 4., specifically with respect to some of the non-clinical operations listed, would be applied in practice. Under this language, would a physician now be responsible for directly negotiating and executing contracts with non-clinical staff like tech support or administrative assistants aiding with patient billing? Would physicians now be responsible for personally setting pricing for services? Rather than broadly prohibiting physicians from entering contracts they deem appropriate, ATA Action encourages the mitigation of these concerns through enforcing existing ethical guardrails and/or requiring the parties clearly delineate and agree to the separate responsibilities.

Furthermore, the PC-MSO structure has helped medical providers access needed financing and investment to expand their practice and innovate, including emerging telehealth companies who aim to reach underserved and often stigmatized populations. The mandates in Section 319B.41 Subd. 4.(b)- with no exception - seem to suggest that an investor would no longer have any input in the shareholders of the medical operation they are supporting, nor could they implement any guardrails to minimize the impact of ownership changes on business operations. If implemented, we believe these requirements would significantly chill investment that has been critical to the deployment of telehealth and healthcare innovation.

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As legal commentators have highlighted,[1] physician practices seeking to attract investment will find doing so challenging if non-physician investors have no effective means to limit financial risk or voice in the leadership of the medical group they are supporting and helping to grow. The ability for lay-entities to invest and partner with physicians in new healthcare ventures – while at the same time ensuring physicians have control over treatment decisions – need not be mutually exclusive endeavors. ATA Action recommends taking an approach focused on empowering physician control over actual treatment decisions and care rather than an approach that restricts their ability to attract and partner with growth investors.

Third, ATA Action has serious concerns with the provision of the legislation (Section 319B.41 Subd. 3.(a)) that requires licensee owners to "exhibit meaningful ownership" "by being present in the state and substantially engaged in delivering medical care or managing the medical practice." By requiring owners to be physically present in Minnesota, this provision is wholly incompatible with the realities of telehealth care as providers often serve patients in many states, including telehealth entities in important fields such as behavioral health, gender-affirming care and reproductive healthcare. This provision also undercuts previous legislation passed by the Legislature that permits out-of-state health care practitioners to provide telehealth services to Minnesota patients through the various licensure compacts of which Minnesota is a member such as the Interstate Medical Licensure Compact, Occupational Therapy Licensure Compact, Psychology Interjurisdictional Compact and Counseling Compact. There is also a significant lack of clarity on what constitutes "meaningful" ownership of a medical practice contemplated here and what subsequent ownership requirements this would implement for telehealth providers operating across state lines. ATA Action recommends removing language that requires an in-state ownership presence and, instead of focusing on new restrictions on ownership, refine the detailed language regarding control and the other guardrails of the Act.

Finally, while much of the dialogue around this legislation has focused on national entities, such as large-scale investor acquisition of institutional medical practices or specific care settings like emergency rooms, it bears emphasis that the mandates in this legislation apply to *every* medical practice and will asymmetrically disadvantage smaller organizations and clinics. Many of our members are emerging entities specializing in niche practice areas like substance abuse treatment, gender affirming care and reproductive health services or are focused on specific patient populations, including the underinsured or Medicaid beneficiaries. These smaller organizations cannot afford the same level of legal planning and restructuring fees larger entities will be capable of absorbing to accommodate the significant changes proposed here. ATA Action fears the overwhelming effect of this legislation will be less investment in, and more pressure on, smaller entities that deliver care and ultimately less access for Minnesota patients.

ATA Action agrees with the apparent overall intent of this legislation to ensure that Minnesota health care providers have control over their clinical decisions. The solution to these well-meaning goals, however, is not to hastily implement this broad and onerous legislation with untested concepts that will – whether intended or not – restrict the growth and development of innovative care models to Minnesota patients. Now is not the time to enact barriers to care. Rather, we encourage robust collaboration with affected stakeholders on a framework that more narrowly addresses the problem at hand, provides entities with

[1] As one commentator noted when the concept of banning succession agreements was proposed, "How can [PCs] attract investment capital if the investors are not permitted to have any say in the shareholders, officers and directors of the medical business they are supporting." https://www.jdsupra.com/legalnews/corporate-practice-of-medicine-on-9931045/

clarity on how the requirements can be practically applied and considers where enforcement of existing regulation could serve as an alternative pathway to ensure provider independence in delivering patient care. Last year Oregon passed corporate practice of medicine legislation which began with many of the same issues present in SF 2939. ATA Action played a key role in this discussion and was able to move to neutral on Oregon's bill after a robust stakeholder process led by the Oregon bill's sponsor and, we hope to do the same here in Minnesota.

Thank you for your consideration of our concerns and interest in telehealth. If you have any questions or would like to discuss further the telehealth industry's perspective, please contact me at hyoung@ataaction.org.

Kind regards,

Hunter Young

Hunter Young
Head of State Government Relations
ATA Action