March 6, 2021

The Honorable Tina Liebling, Chair
Health Finance and Policy Committee
Minnesota House of Representatives
477 State Office Building
St. Paul, MN 55155

The Honorable Joe Schomacker, GOP Lead
Health Finance and Policy Committee
Minnesota House of Representatives
209 State Office Building
St. Paul, MN 55155

The Honorable John Huot, Vice Chair
Health Finance and Policy Committee
Minnesota House of Representatives
583 State Office Building
St. Paul, MN 55155

RE: HF 1412 – Minnesota Telehealth Act

Dear Chair Liebling, Vice Chair Huot, GOP Lead Schomacker, and Members of the Committee:

The Legal Services Advocacy Project (LSAP) and the Minnesota Disability Law Center (MDLC) write to express our interest in continued conversations about HF 1412 (Minnesota Telehealth Act), which would make several changes to telehealth in Minnesota, including expanding telehealth reimbursement within Medical Assistance. We appreciate the interest in expanding telehealth utilization in Minnesota, and we recognize the benefits that expanded use of telehealth has offered during the public health emergency. We are grateful to the authors of this bill for their work on this proposal and look forward to continued conversation.

LSAP is the advocacy arm of Legal Aid and has provided legislative and administrative advocacy on behalf of Legal Aid's clients and all low-income Minnesotans since 1977. MDLC, a statewide division of Mid-Minnesota Lega Aid, serves as Minnesota's Protection and Advocacy (P&A) organization and is part of network of national, legally based advocacy services for people with disabilities in the United States. MDLC provides free legal services to children and adults with disabilities.

Below we identify specific areas for further consideration that relate to the communities we serve – elderly, low-income, people who have disabilities, rural communities, and BIPOC communities in Minnesota and those enrolled in Medical Assistance.

Several telehealth studies since the onset of the public health emergency have pointed to disproportionately lower telehealth utilization by BIPOC communities. A December 2020 study found Black and Latinx patients, as well as patients with a median household income below $50,000, had significantly lower rates of video-based telehealth visits.[1] The same study found that patients with a non-English preferred language had 16 percent lower telehealth visits of any type.

Further, in a recent article in the New England Journal of Medicine, a team of primary care physicians warned that disparate use of telehealth "has alarming implications for inadequate chronic disease management" and "may result in increased disparities in clinical outcomes."[2] Drawing from an analysis of claims data in Minnesota, the recent DHS review of COVID-19 telemedicine utilization recommended that policymakers "invest resources in exploring reasons behind comparatively low level of utilization of telemedicine by Black, Indigenous, and People of Color (BIPOC) communities."[3]

Rural and elderly Minnesotans and Minnesotans who have disabilities may also face significant obstacles to effective use of telehealth services. Inadequate broadband access throughout much of rural Minnesota poses a significant barrier to access and quality of telehealth. Elderly Minnesotans also face barriers around access and digital literacy. Among adults in the U.S. who are 65 years old or older (who constitute 18% of the American population and are most likely to need chronic disease management) only 55% to 60% own a smartphone or have home broadband access.[4] Minnesotans who have disabilities may face specific barriers to using telehealth and, for some people and types of visits, in-person care may be much more appropriate.[5]

Further study is also warranted on the health outcomes and quality of care for telehealth versus in-person visits, and between telehealth modalities. Significant differences exist in how patients are evaluated and treated remotely versus in-person, and the recent increase in telehealth utilization provides a rich opportunity to better understand which conditions are most appropriate for diagnosis and treatment via telehealth.

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[1] Lauren A. Eberly, MD, MPH; Michael J. Kallan, MS; Howard M. Julien, MD, MPH, ML; et al., *Patient Characteristics Associated With Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic* (Journal of the American Medical Association, JAMA Network, December 29, 2020); at https://jamanetwork.com/journals/jamanetworkopen/ fullarticle/2774488.

[2] Sarah Nouri, MD, MPH; Elaine C. Khoong, MD, MS; Courtney R. Lyles, PhD & Leah Karliner, MD, MAS, *Addressing Equity in Telemedicine for Chronic Disease Management During the Covid-19 Pandemic* (New England Journal of Medicine Catalyst, May 4, 2020); at https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0123.

[3] Minnesota Department of Health, *Telemedicine Utilization Report: Telehealth and Telemedicine during the COVID-19 Pandemic* (Dec. 16, 2020); at https://mn.gov/dhs/assets/telemedicine-utilization-report-2020_tcm1053-458660.pdf.

[4] Nouri, et. al., *Addressing Equity in Telecmedicine, supra* note 2.

[5] Thiru M. Annaswamy, Monica Verduzco-Gutierrez, and Lex Frieden*, Telemedicine barriers and challenges for persons with disabilities: COVID-19 and beyond*, 13 DISABIL. HEALTH J. (OCT. 2020).

The patient experience can also vary significantly based on which telehealth modality is used. Data are limited to date on utilization and outcomes related to telephone-only visits, and we would urge further study of this telehealth modality in particular before permanent decisions are made related to MA payment. Furthermore, it remains to be seen how telehealth options would impact the availability of in-person care options. It is essential that people on Medical Assistance across the state continue to have meaningful options for in-person care.

In sum, expanded use of telehealth has offered significant benefits during the public health emergency, and we recognize the potential that telehealth holds to mitigate some barriers in access to care, including for more vulnerable Minnesotans. We also recognize that broad expansion of telehealth could exacerbate health inequities in Minnesota. We would urge policymakers to gather more data on utilization and outcomes, particularly for low-income and BIPOC communities and people who have disabilities, including through direct feedback from Medicaid enrollees. If we take the time to delve into the complexities of telehealth around access and quality, particularly for Minnesotans who are part of groups with historically disparate health outcomes, we can ensure that telehealth policies are best tailored to meet the needs of all Minnesotans.

Thank you for the opportunity to share our views. Again, we are grateful to the authors for their work on this proposal and look forward to continued conversations on this important issue.

Sincerely,

Ron Elwood
Supervising Attorney
Legal Services Advocacy Project

Maren Hulden
Staff Attorney
Legal Services Advocacy Project

CC: Representative Kelly Morrison