SENATE
STATE OF MINNESOTA
NINETY-SECOND SESSION

S.F. No. 1160

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DATE	D-PG	OFFICIAL STATUS
02/18/2021	455	Introduction and first reading Referred to Health and Human Services Finance and Policy
02/25/2021	507a	Comm report: To pass as amended and re-refer to Commerce and Consumer Protection Finance and Policy
	574	Authors added Nelson; Klein
03/04/2021	639a	Comm report: To pass as amended and re-refer to Human Services Reform Finance and Policy
03/10/2021	785a	Comm report: To pass as amended and re-refer to Health and Human Services Finance and Policy
03/18/2021	1060a	Comm report: To pass as amended and re-refer to State Government Finance and Policy and Elections
03/25/2021	1162a	Comm report: To pass as amended and re-refer to Rules and Administration Joint rule 2.03, referred to Rules and Administration
04/06/2021	1207	Joint rule 2.03 Suspended amend previous committee report Re-referred to Finance
04/26/2021	3088a	Comm report: To pass as amended
	3235	Second reading
04/27/2021	3975a	Special Order: Amended
	3977	Third reading Passed See First Special Session 2021, HF33, Art. 6

A bill for an act

relating to health care; modifying coverage for health care services and consultation provided through telehealth; establishing a task force on creating a person-centered telepresence strategy; amending Minnesota Statutes 2020, sections 147.033; 151.37, subdivision 2; 245G.01, subdivisions 13, 26; 245G.06, subdivision 1; 254A.19, subdivision 5; 254B.05, subdivision 5; 256B.0621, subdivision 10; 256B.0622, subdivision 7a; 256B.0625, subdivisions 3b, 13h, 20, 20b, 46, by adding a subdivision; 256B.0924, subdivision 6; 256B.094, subdivision 6; 256B.0943, subdivision 1; 256B.0947, subdivision 6; 256B.0949, subdivision 13; proposing coding for new law in Minnesota Statutes, chapter 62A; repealing Minnesota Statutes 2020, sections 62A.67; 62A.671; 62A.672; 256B.0596; 256B.0924, subdivision 4a.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[62A.673] COVERAGE OF SERVICES PROVIDED THROUGH TELEHEALTH.**

Subdivision 1. **Citation.** This section may be cited as the "Minnesota Telehealth Act."

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Distant site" means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.

(c) "Health care provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law. A health care provider includes a mental health professional as defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; a mental health practitioner as defined under section 245.462, subdivision 17, or 245.4871, subdivision 26; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor

under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

(d) "Health carrier" has the meaning given in section 62A.011, subdivision 2.

(e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

(f) "Originating site" means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth. For purposes of store-and-forward transfer, the originating site also means the location at which a health care provider transfers or transmits information to the distant site.

(g) "Store-and-forward technology" means the asynchronous electronic technology of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

(h) "Telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual or audio-only communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Telehealth includes audio-only communication between a health care provider and a patient if the communication is a scheduled appointment and the standard of care for the service can be met through the use of audio-only communication. Telehealth does not include communication between health care providers or between a health care provider and a patient that consists solely of an e-mail or facsimile transmission. Telehealth does not include communication between health care providers that consists solely of a telephone conversation. Telehealth does not include telemonitoring services as defined in paragraph (i).

(i) "Telemonitoring services" means the remote monitoring of clinical data related to the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect an enrollee's health-related data for the purpose of assisting a health care provider in assessing and monitoring the enrollee's medical condition or status.

Subd. 3. **Coverage of telehealth.** (a) A health plan sold, issued, or renewed by a health carrier in Minnesota must (1) cover benefits delivered through telehealth in the same manner as any other benefits covered under the health plan, and (2) comply with this section.

(b) Coverage for services delivered through telehealth must not be limited on the basis of geography, location, or distance for travel subject to the health care provider network available to the enrollee through the enrollee's health plan.

(c) A health carrier must not create a separate provider network to deliver services through telehealth that does not include network providers who provide in-person care to patients for the same service or require an enrollee to use a specific provider within the network to receive services through telehealth.

(d) A health carrier may require a deductible, co-payment, or coinsurance payment for a health care service provided through telehealth, provided that the deductible, co-payment, or coinsurance payment is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable for the same service provided through in-person contact.

(e) Nothing in this section:

(1) requires a health carrier to provide coverage for services that are not medically necessary or are not covered under the enrollee's health plan; or

(2) prohibits a health carrier from:

(i) establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service through telehealth for which the health carrier does not already reimburse other health care providers for delivering the service through telehealth; or

(ii) establishing reasonable medical management techniques, provided the criteria or techniques are not unduly burdensome or unreasonable for the particular service; or

(iii) requiring documentation or billing practices designed to protect the health carrier or patient from fraudulent claims, provided the practices are not unduly burdensome or unreasonable for the particular service.

(f) Nothing in this section requires the use of telehealth when a health care provider determines that the delivery of a health care service through telehealth is not appropriate or when an enrollee chooses not to receive a health care service through telehealth.

Subd. 4. **Parity between telehealth and in-person services.** (a) A health carrier must not restrict or deny coverage of a health care service that is covered under a health plan solely:

(1) because the health care service provided by the health care provider through telehealth is not provided through in-person contact; or

(2) based on the communication technology or application used to deliver the health care service through telehealth, provided the technology or application complies with this section and is appropriate for the particular service.

(b) Prior authorization may be required for health care services delivered through telehealth only if prior authorization is required before the delivery of the same service through in-person contact.

(c) A health carrier may require a utilization review for services delivered through telehealth, provided the utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for the same services delivered through in-person contact.

(d) A health carrier or health care provider shall not require an enrollee to pay a fee to download a specific communication technology or application.

Subd. 5. **Reimbursement for services delivered through telehealth.** (a) A health carrier must reimburse the health care provider for services delivered through telehealth on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered by the health care provider through in-person contact.

(b) A health carrier must not deny or limit reimbursement based solely on a health care provider delivering the service or consultation through telehealth instead of through in-person contact.

(c) A health carrier must not deny or limit reimbursement based solely on the technology and equipment used by the health care provider to deliver the health care service or consultation through telehealth, provided the technology and equipment used by the provider meets the requirements of this section and is appropriate for the particular service.

Subd. 6. **Telehealth equipment.** (a) A health carrier must not require a health care provider to use specific telecommunications technology and equipment as a condition of coverage under this section, provided the health care provider uses telecommunications technology and equipment that complies with current industry interoperable standards and complies with standards required under the federal Health Insurance Portability and

Accountability Act of 1996, Public Law 104-191, and regulations promulgated under that Act, unless authorized under this section.

(b) A health carrier must provide coverage for health care services delivered through telehealth by means of the use of audio-only communication if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication.

(c) Notwithstanding paragraph (b), substance use disorder treatment services and mental health services delivered through telehealth by means of audio-only communication may be covered without a scheduled appointment if the communication was initiated by the enrollee while in an emergency or crisis situation and a scheduled appointment was not possible due to the need of an immediate response.

Subd. 7. **Telemonitoring services.** A health carrier must provide coverage for telemonitoring services if:

(1) the telemonitoring service is medically appropriate based on the enrollee's medical condition or status;

(2) the enrollee is cognitively and physically capable of operating the monitoring device or equipment, or the enrollee has a caregiver who is willing and able to assist with the monitoring device or equipment; and

(3) the enrollee resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

Subd. 8. **Exception.** This section does not apply to coverage provided to state public health care program enrollees under chapter 256B or 256L.

Sec. 2. Minnesota Statutes 2020, section 147.033, is amended to read:

147.033 PRACTICE OF ~~TELEMEDICINE~~ TELEHEALTH.

Subdivision 1. **Definition.** For the purposes of this section, ~~"telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way interactive audio, and visual~~

~~communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, that facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.~~ "telehealth" has the meaning given in section 62A.673, subdivision 2, paragraph (h).

Subd. 2. **Physician-patient relationship.** A physician-patient relationship may be established through ~~telemedicine~~ telehealth.

Subd. 3. **Standards of practice and conduct.** A physician providing health care services by ~~telemedicine~~ telehealth in this state shall be held to the same standards of practice and conduct as provided in this chapter for in-person health care services.

Sec. 3. Minnesota Statutes 2020, section 151.37, subdivision 2, is amended to read:

Subd. 2. **Prescribing and filing.** (a) A licensed practitioner in the course of professional practice only, may prescribe, administer, and dispense a legend drug, and may cause the same to be administered by a nurse, a physician assistant, or medical student or resident under the practitioner's direction and supervision, and may cause a person who is an appropriately certified, registered, or licensed health care professional to prescribe, dispense, and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference to a specific patient, by directing a licensed dietitian or licensed nutritionist, pursuant to section 148.634; a nurse, pursuant to section 148.235, subdivisions 8 and 9; physician assistant; medical student or resident; or pharmacist according to section 151.01, subdivision 27, to adhere to a particular practice guideline or protocol when treating patients whose condition falls within such guideline or protocol, and when such guideline or protocol specifies the circumstances under which the legend drug is to be prescribed and administered. An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug. This paragraph applies to a physician assistant only if the physician assistant meets the requirements of ~~section 147A.18~~ sections 147A.02 and 147A.09.

(b) The commissioner of health, if a licensed practitioner, or a person designated by the commissioner who is a licensed practitioner, may prescribe a legend drug to an individual or by protocol for mass dispensing purposes where the commissioner finds that the conditions triggering section 144.4197 or 144.4198, subdivision 2, paragraph (b), exist. The commissioner, if a licensed practitioner, or a designated licensed practitioner, may prescribe, dispense, or administer a legend drug or other substance listed in subdivision 10 to control tuberculosis and other communicable diseases. The commissioner may modify state drug

labeling requirements, and medical screening criteria and documentation, where time is critical and limited labeling and screening are most likely to ensure legend drugs reach the maximum number of persons in a timely fashion so as to reduce morbidity and mortality.

(c) A licensed practitioner that dispenses for profit a legend drug that is to be administered orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the practitioner's licensing board a statement indicating that the practitioner dispenses legend drugs for profit, the general circumstances under which the practitioner dispenses for profit, and the types of legend drugs generally dispensed. It is unlawful to dispense legend drugs for profit after July 31, 1990, unless the statement has been filed with the appropriate licensing board. For purposes of this paragraph, "profit" means (1) any amount received by the practitioner in excess of the acquisition cost of a legend drug for legend drugs that are purchased in prepackaged form, or (2) any amount received by the practitioner in excess of the acquisition cost of a legend drug plus the cost of making the drug available if the legend drug requires compounding, packaging, or other treatment. The statement filed under this paragraph is public data under section 13.03. This paragraph does not apply to a licensed doctor of veterinary medicine or a registered pharmacist. Any person other than a licensed practitioner with the authority to prescribe, dispense, and administer a legend drug under paragraph (a) shall not dispense for profit. To dispense for profit does not include dispensing by a community health clinic when the profit from dispensing is used to meet operating expenses.

(d) A prescription drug order for the following drugs is not valid, unless it can be established that the prescription drug order was based on a documented patient evaluation, including an examination, adequate to establish a diagnosis and identify underlying conditions and contraindications to treatment:

(1) controlled substance drugs listed in section 152.02, subdivisions 3 to 5;

(2) drugs defined by the Board of Pharmacy as controlled substances under section 152.02, subdivisions 7, 8, and 12;

(3) muscle relaxants;

(4) centrally acting analgesics with opioid activity;

(5) drugs containing butalbital; or

(6) phosphodiesterase type 5 inhibitors when used to treat erectile dysfunction.

~~For purposes of prescribing drugs listed in clause (6), the requirement for a documented patient evaluation, including an examination, may be met through the use of telemedicine, as defined in section 147.033, subdivision 1.~~

(e) For the purposes of paragraph (d), the requirement for an examination shall be met if:

(1) an in-person examination has been completed in any of the following circumstances:

~~(1)~~ (i) the prescribing practitioner examines the patient at the time the prescription or drug order is issued;

~~(2)~~ (ii) the prescribing practitioner has performed a prior examination of the patient;

~~(3)~~ (iii) another prescribing practitioner practicing within the same group or clinic as the prescribing practitioner has examined the patient;

~~(4)~~ (iv) a consulting practitioner to whom the prescribing practitioner has referred the patient has examined the patient; or

~~(5)~~ (v) the referring practitioner has performed an examination in the case of a consultant practitioner issuing a prescription or drug order when providing services by means of telemedicine~~.~~; or

(2) the prescription order is for a drug listed in paragraph (d), clause (6), or for medication assisted therapy for a substance use disorder, and the prescribing practitioner has completed an examination of the patient via telehealth as defined in section 62A.673, subdivision 2, paragraph (h).

(f) Nothing in paragraph (d) or (e) prohibits a licensed practitioner from prescribing a drug through the use of a guideline or protocol pursuant to paragraph (a).

(g) Nothing in this chapter prohibits a licensed practitioner from issuing a prescription or dispensing a legend drug in accordance with the Expedited Partner Therapy in the Management of Sexually Transmitted Diseases guidance document issued by the United States Centers for Disease Control.

(h) Nothing in paragraph (d) or (e) limits prescription, administration, or dispensing of legend drugs through a public health clinic or other distribution mechanism approved by the commissioner of health or a community health board in order to prevent, mitigate, or treat a pandemic illness, infectious disease outbreak, or intentional or accidental release of a biological, chemical, or radiological agent.

(i) No pharmacist employed by, under contract to, or working for a pharmacy located within the state and licensed under section 151.19, subdivision 1, may dispense a legend drug based on a prescription that the pharmacist knows, or would reasonably be expected to know, is not valid under paragraph (d).

(j) No pharmacist employed by, under contract to, or working for a pharmacy located outside the state and licensed under section 151.19, subdivision 1, may dispense a legend drug to a resident of this state based on a prescription that the pharmacist knows, or would reasonably be expected to know, is not valid under paragraph (d).

(k) Nothing in this chapter prohibits the commissioner of health, if a licensed practitioner, or, if not a licensed practitioner, a designee of the commissioner who is a licensed practitioner, from prescribing legend drugs for field-delivered therapy in the treatment of a communicable disease according to the Centers For Disease Control and Prevention Partner Services Guidelines.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 4. Minnesota Statutes 2020, section 245G.01, subdivision 13, is amended to read:

Subd. 13. **Face-to-face.** "Face-to-face" means two-way, real-time, interactive ~~and visual~~ communication between a client and a treatment service provider and includes services delivered in person or via ~~telemedicine~~ telehealth.

Sec. 5. Minnesota Statutes 2020, section 245G.01, subdivision 26, is amended to read:

Subd. 26. ~~**Telemedicine**~~ **Telehealth.** ~~"Telemedicine"~~ "Telehealth" means the delivery of a substance use disorder treatment service while the client is at an originating site and the ~~licensed~~ health care provider is at a distant site via telehealth as defined in section 256B.0625, subdivision 3b, and as specified in section 254B.05, subdivision 5, paragraph (f).

Sec. 6. Minnesota Statutes 2020, section 245G.06, subdivision 1, is amended to read:

Subdivision 1. **General.** Each client must have a person-centered individual treatment plan developed by an alcohol and drug counselor within ten days from the day of service initiation for a residential program and within five calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the

development of the plan. The individual treatment plan is developed upon the qualified staff member's dated signature. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition, the client's level of participation, and on whether methods identified have the intended effect. A change to the plan must be signed by the client and the alcohol and drug counselor. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. If a client is receiving treatment services or an assessment via telehealth and the alcohol and drug counselor documents the reason the client's signature cannot be obtained, the alcohol and drug counselor may document the client's verbal approval of the treatment plan or change to the treatment plan in lieu of the client's signature.

Sec. 7. Minnesota Statutes 2020, section 254A.19, subdivision 5, is amended to read:

Subd. 5. **Assessment via ~~telemedicine~~ telehealth.** Notwithstanding Minnesota Rules, part 9530.6615, subpart 3, item A, a chemical use assessment may be conducted via ~~telemedicine~~ telehealth as defined in section 256B.0625, subdivision 3b.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 8. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

(3) care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) medication-assisted therapy services that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(9) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(12) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via ~~two-way interactive video~~ telehealth as defined in section 256B.0625, subdivision 3b. The use of ~~two-way interactive video~~ telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. ~~The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.~~

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

Sec. 9. Minnesota Statutes 2020, section 256B.0621, subdivision 10, is amended to read:

Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

(1) for relocation targeted case management, case managers may bill for direct case management activities, including face-to-face contact, telephone contact, and interactive video contact ~~according to section 256B.0924, subdivision 4a,~~ in the lesser of:

(i) 180 days preceding an eligible recipient's discharge from an institution; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service;

(2) for home care targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts; and

(3) billings for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

Sec. 10. Minnesota Statutes 2020, section 256B.0622, subdivision 7a, is amended to read:

Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

(i) shall be a licensed mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role but must obtain full licensure within 24 months of assuming the role of team leader;

(ii) must be an active member of the ACT team and provide some direct services to clients;

(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team, providing clinical oversight of services in conjunction with the psychiatrist or psychiatric care provider, and supervising team members to ensure delivery of best and ethical practices; and

(iv) must be available to provide overall clinical oversight to the ACT team after regular business hours and on weekends and holidays. The team leader may delegate this duty to another qualified member of the ACT team;

(2) the psychiatric care provider:

(i) must be a licensed psychiatrist certified by the American Board of Psychiatry and Neurology or eligible for board certification or certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness;

(ii) shall collaborate with the team leader in sharing overall clinical responsibility for screening and admitting clients; monitoring clients' treatment and team member service delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,

and health-related conditions; actively collaborating with nurses; and helping provide clinical supervision to the team;

(iii) shall fulfill the following functions for assertive community treatment clients: provide assessment and treatment of clients' symptoms and response to medications, including side effects; provide brief therapy to clients; provide diagnostic and medication education to clients, with medication decisions based on shared decision making; monitor clients' nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and community visits;

(iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized for mental health treatment and shall communicate directly with the client's inpatient psychiatric care providers to ensure continuity of care;

(v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per 50 clients. Part-time psychiatric care providers shall have designated hours to work on the team, with sufficient blocks of time on consistent days to carry out the provider's clinical, supervisory, and administrative responsibilities. No more than two psychiatric care providers may share this role;

(vi) may ~~not~~ provide ~~specific roles and responsibilities by telemedicine unless approved by the commissioner~~ services through telehealth as defined under section 256B.0625, subdivision 3b, when necessary to ensure the continuation of psychiatric and medication services availability for clients and to maintain statutory requirements for psychiatric care provider staffing levels; and

(vii) shall provide psychiatric backup to the program after regular business hours and on weekends and holidays. The psychiatric care provider may delegate this duty to another qualified psychiatric provider;

(3) the nursing staff:

(i) shall consist of one to three registered nurses or advanced practice registered nurses, of whom at least one has a minimum of one-year experience working with adults with serious mental illness and a working knowledge of psychiatric medications. No more than two individuals can share a full-time equivalent position;

(ii) are responsible for managing medication, administering and documenting medication treatment, and managing a secure medication room; and

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and

medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

(i) shall be a full-time equivalent co-occurring disorder specialist who has received specific training on co-occurring disorders that is consistent with national evidence-based practices. The training must include practical knowledge of common substances and how they affect mental illnesses, the ability to assess substance use disorders and the client's stage of treatment, motivational interviewing, and skills necessary to provide counseling to clients at all different stages of change and treatment. The co-occurring disorder specialist may also be an individual who is a licensed alcohol and drug counselor as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience, and other requirements in section 245G.11, subdivision 5. No more than two co-occurring disorder specialists may occupy this role; and

(ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients. The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT team members on co-occurring disorders;

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services to individuals with mental illness. An individual who does not meet these qualifications may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

(ii) shall provide or facilitate the provision of vocational services to clients. The vocational specialist serves as a consultant and educator to fellow ACT team members on these services; and

(iii) should not refer individuals to receive any type of vocational services or linkage by providers outside of the ACT team;

(6) the mental health certified peer specialist:

(i) shall be a full-time equivalent mental health certified peer specialist as defined in section 256B.0615. No more than two individuals can share this position. The mental health certified peer specialist is a fully integrated team member who provides highly individualized

services in the community and promotes the self-determination and shared decision-making abilities of clients. This requirement may be waived due to workforce shortages upon approval of the commissioner;

(ii) must provide coaching, mentoring, and consultation to the clients to promote recovery, self-advocacy, and self-direction, promote wellness management strategies, and assist clients in developing advance directives; and

(iii) must model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience, provide consultation to team members, promote a culture where the clients' points of view and preferences are recognized, understood, respected, and integrated into treatment, and serve in a manner equivalent to other team members;

(7) the program administrative assistant shall be a full-time office-based program administrative assistant position assigned to solely work with the ACT team, providing a range of supports to the team, clients, and families; and

(8) additional staff:

(i) shall be based on team size. Additional treatment team staff may include licensed mental health professionals as defined in Minnesota Rules, part 9505.0371, subpart 5, item A; mental health practitioners as defined in section 245.462, subdivision 17; a mental health practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C; or mental health rehabilitation workers as defined in section 256B.0623, subdivision 5, paragraph (a), clause (4). These individuals shall have the knowledge, skills, and abilities required by the population served to carry out rehabilitation and support functions; and

(ii) shall be selected based on specific program needs or the population served.

(b) Each ACT team must clearly document schedules for all ACT team members.

(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.

(d) Members of the ACT team must have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of rehabilitation services. Each staff member shall be proficient in their respective discipline and be able to work collaboratively

as a member of a multidisciplinary team to deliver the majority of the treatment, rehabilitation, and support services clients require to fully benefit from receiving assertive community treatment.

(e) Each ACT team member must fulfill training requirements established by the commissioner.

Sec. 11. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. ~~**Telemedicine**~~ **Telehealth services.** (a) Medical assistance covers medically necessary services and consultations delivered by a ~~licensed~~ health care provider ~~via telemedicine~~ through telehealth in the same manner as if the service or consultation was delivered ~~in person~~ through in-person contact. ~~Coverage is limited to three telemedicine services per enrollee per calendar week, except as provided in paragraph (f). Telemedicine~~ Services or consultations delivered through telehealth shall be paid at the full allowable rate.

(b) The commissioner ~~shall~~ may establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service ~~via telemedicine~~ through telehealth. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide ~~via telemedicine~~ through telehealth;

(2) has written policies and procedures specific to ~~telemedicine~~ services delivered through telehealth that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the ~~telemedicine~~ service is ~~rendered~~ delivered through telehealth;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to ~~telemedicine~~ delivering services through telehealth.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service ~~provided by telemedicine~~ delivered through telehealth to a medical assistance enrollee. Health care service records for services ~~provided by telemedicine~~ delivered through telehealth must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service ~~provided by telemedicine~~ delivered through telehealth;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the ~~licensed~~ health care provider's basis for determining that ~~telemedicine~~ telehealth is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission ~~of~~ used to deliver the ~~telemedicine~~ service through telehealth and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's ~~telemedicine~~ consultation with another physician through telehealth, the written opinion from the consulting physician providing the ~~telemedicine~~ telehealth consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) Telehealth visits, as described in this subdivision provided through audio and visual communication, may be used to satisfy the face-to-face requirement for reimbursement under the payment methods that apply to a federally qualified health center, rural health clinic, Indian health service, 638 tribal clinic, and certified community behavioral health clinic, if the service would have otherwise qualified for payment if performed in person.

(e) For mental health services or assessments delivered through telehealth that are based on an individual treatment plan, the provider may document the client's verbal approval of the treatment plan or change in the treatment plan in lieu of the client's signature in accordance with Minnesota Rules, part 9505.0371.

~~(d)~~ (f) For purposes of this subdivision, unless otherwise covered under this chapter~~,~~ ~~"telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.~~:

(1) "telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communication to provide or support

health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Telehealth does not include communication between health care providers or between a health care provider and a patient that consists solely of an audio-only communication, an e-mail, or a facsimile transmission unless authorized by the commissioner or specified by law;

~~(e) For purposes of this section, "licensed~~ (2) "health care provider" means a ~~licensed~~ health care provider ~~under section 62A.671, subdivision 6~~ as defined under section 62A.673, a community paramedic as defined under section 144E.001, subdivision 5f, ~~or a mental health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional, and~~ a community health worker who meets the criteria under subdivision 49, paragraph (a)~~; "health care provider" is defined under section 62A.671, subdivision 3;~~, a mental health certified peer specialist under section 256B.0615, subdivision 5, a mental health certified family peer specialist under section 256B.0616, subdivision 5, a mental health rehabilitation worker under section 256B.0623, subdivision 5, paragraph (a), clause (4), and paragraph (b), a mental health behavioral aide under section 256B.0943, subdivision 7, paragraph (b), clause (3), a treatment coordinator under section 245G.11, subdivision 7, an alcohol and drug counselor under section 245G.11, subdivision 5, a recovery peer under section 245G.11, subdivision 8; and

(3) "originating site" ~~is defined under section 62A.671, subdivision 7~~, "distant site," and "store-and-forward technology" have the meanings given in section 62A.673, subdivision 2.

~~(f) The limit on coverage of three telemedicine services per enrollee per calendar week does not apply if:~~

~~(1) the telemedicine services provided by the licensed health care provider are for the treatment and control of tuberculosis; and~~

~~(2) the services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the commissioner of health.~~

Sec. 12. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 3h. **Telemonitoring services.** (a) Medical assistance covers telemonitoring services if:

(1) the telemonitoring service is medically appropriate based on the recipient's medical condition or status;

(2) the recipient's health care provider has identified that telemonitoring services would likely prevent the recipient's admission or readmission to a hospital, emergency room, or nursing facility;

(3) the recipient is cognitively and physically capable of operating the monitoring device or equipment, or the recipient has a caregiver who is willing and able to assist with the monitoring device or equipment; and

(4) the recipient resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

(b) For purposes of this subdivision, "telemonitoring services" means the remote monitoring of data related to a recipient's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a provider for analysis. The assessment and monitoring of the health data transmitted by telemonitoring must be performed by one of the following licensed health care professionals: physician, podiatrist, registered nurse, advanced practice registered nurse, physician assistant, respiratory therapist, or licensed professional working under the supervision of a medical director.

Sec. 13. Minnesota Statutes 2020, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance covers medication therapy management services for a recipient taking prescriptions to treat or prevent one or more chronic medical conditions. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan, which may include prescribing medications or products in accordance with section 151.37, subdivision 14, 15, or 16;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued by the Board of Pharmacy of the state in which the medication therapy management service is being performed;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements; and

~~(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, including long-term care settings, group homes, and facilities providing assisted living services, but excluding skilled nursing facilities; and~~

~~(4)~~ (3) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance providers. The

commissioner may also establish ~~contact requirements between the pharmacist and recipient, including limiting~~ limits on the number of reimbursable consultations per recipient.

(d) ~~If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide The~~ Medication therapy management services may be provided via ~~two-way interactive video~~ telehealth as defined in subdivision 3b and may be delivered into a patient's residence. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b)~~, and must be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3). The patient must also be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3). Services provided under this paragraph may not be transmitted into the patient's residence~~.

~~(e) Medication therapy management services may be delivered into a patient's residence via secure interactive video if the medication therapy management services are performed electronically during a covered home care visit by an enrolled provider. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b) and must be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3).~~

Sec. 14. Minnesota Statutes 2020, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the

provider must document at least a face-to-face contact either in person or by interactive video that meets the requirements of subdivision 20b with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative ~~or a contact by interactive video~~ either in person or by interactive video that meets the requirements of subdivision 20b; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact ~~or a contact by interactive video~~ either in person or by interactive video that meets the requirements of subdivision 20b with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include the federal earnings, the state share, and the county share.

(m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(p) If the recipient is receiving care in a hospital, nursing facility, or residential setting licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week, mental health targeted case management services must actively support identification of community alternatives for the recipient and discharge planning.

Sec. 15. Minnesota Statutes 2020, section 256B.0625, subdivision 20b, is amended to read:

Subd. 20b. **~~Mental health~~ Targeted case management ~~through~~ by interactive video.** (a) ~~Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment if:~~ Minimum required face-to-face contacts for targeted case management may be provided by interactive video if interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian and the case management provider.

~~(1) the person receiving targeted case management services is residing in:~~

~~(i) a hospital;~~

~~(ii) a nursing facility; or~~

~~(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;~~

~~(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;~~

~~(3) the use of interactive video is approved as part of the person's written personal service or case plan, taking into consideration the person's vulnerability and active personal relationships; and~~

~~(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contact.~~

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner ~~shall~~ may establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of ~~delivering the service via interactive video. The attestation may include that the case management provider has:~~ meeting the minimum face-to-face contact requirements for targeted case management by interactive video.

~~(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;~~

~~(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;~~

~~(3) established protocols addressing how and when to discontinue interactive video services; and~~

~~(4) established a quality assurance process related to interactive video services.~~

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video for the purposes of face-to-face contact:

(1) the time the ~~service~~ contact began and the time the service ended, including an a.m. and p.m. designation;

(2) the basis for determining that interactive video is an appropriate and effective means for ~~delivering the service to~~ contacting the person receiving targeted case management services;

(3) the mode of transmission of the ~~interactive video~~ services delivered by interactive video and records ~~evidencing~~ stating that a particular mode of transmission was utilized; and

(4) the location of the originating site and the distant site~~; and~~.

~~(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).~~

(e) Interactive video must not be used to meet minimum face-to-face contact requirements for children receiving case management services for child protection reasons or who are in out-of-home placement.

(f) For purposes of this section, "interactive video" means the delivery of targeted case management services in real time through the use of two-way interactive audio and visual communication.

Sec. 16. Minnesota Statutes 2020, section 256B.0625, subdivision 46, is amended to read:

Subd. 46. **Mental health ~~telemedicine~~ telehealth.** ~~Effective January 1, 2006, and~~ Subject to federal approval, mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via ~~two-way interactive video~~ telehealth as defined in subdivision 3b. Use of ~~two-way interactive video~~ telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the service. ~~The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.~~

Sec. 17. Minnesota Statutes 2020, section 256B.0924, subdivision 6, is amended to read:

Subd. 6. **Payment for targeted case management.** (a) Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis. In order to receive payment for an eligible adult, the provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact either in person or by interactive video that meets the requirements in section 256B.0625, subdivision 20b, with the adult or the adult's legal representative, family, primary caregiver, or other relevant persons identified as necessary to the development or implementation of the goals of the personal service plan.

(b) Payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of December 31, 2001. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

(c) Payment for targeted case management provided by county-contracted vendors shall be based on a monthly rate negotiated by the host county. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

(d) If the service is provided by a team that includes contracted vendors and county staff, the costs for county staff participation on the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the recipient's file, the need for team targeted case management and a description of the different roles of the team members.

(e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for targeted case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(f) The commissioner may suspend, reduce, or terminate reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal disallowances. The county may share this responsibility with its contracted vendors.

(g) The commissioner shall set aside five percent of the federal funds received under this section for use in reimbursing the state for costs of developing and implementing this section.

(h) Payments to counties for targeted case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to contracted vendors shall include both the federal earnings and the county share.

(i) Notwithstanding section 256B.041, county payments for the cost of case management services provided by county staff shall not be made to the commissioner of management and budget. For the purposes of targeted case management services provided by county staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for targeted case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(k) Payment for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(l) Any growth in targeted case management services and cost increases under this section shall be the responsibility of the counties.

Sec. 18. Minnesota Statutes 2020, section 256B.094, subdivision 6, is amended to read:

Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical assistance reimbursement for services under this section shall be made on a monthly basis. Payment is based on face-to-face or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. These contacts must meet the ~~minimum standards~~ requirements in clauses (1) ~~and (2)~~ to (3):

(1) there must be a face-to-face contact at least once a month except as provided in ~~clause~~ clauses (2) and (3); ~~and~~

(2) for a client placed outside of the county of financial responsibility, or a client served by tribal social services placed outside the reservation, in an excluded time facility under section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of Children, section 260.93, and the placement in either case is more than 60 miles beyond the county or reservation boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face ~~contact.~~ in-person contact; and

(3) for a child receiving case management services for child protection reasons or who is in out-of-home placement, face-to-face contact must be through in-person contact.

(b) Except as provided under paragraph (c), the payment rate is established using time study data on activities of provider service staff and reports required under sections 245.482 and 256.01, subdivision 2, paragraph (p).

(c) Payments for tribes may be made according to section 256B.0625 or other relevant federally approved rate setting methodology for child welfare targeted case management provided by Indian health services and facilities operated by a tribe or tribal organization.

(d) Payment for case management provided by county or tribal social services contracted vendors shall be based on a monthly rate negotiated by the host county or tribal social services. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribal social services may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No

reimbursement received by contracted vendors shall be returned to the county or tribal social services, except to reimburse the county or tribal social services for advance funding provided by the county or tribal social services to the vendor.

(e) If the service is provided by a team that includes contracted vendors and county or tribal social services staff, the costs for county or tribal social services staff participation in the team shall be included in the rate for county or tribal social services provided services. In this case, the contracted vendor and the county or tribal social services may each receive separate payment for services provided by each entity in the same month. To prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles and services of the team members.

Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study, or under paragraph (c), shall be distributed according to earnings, to counties, reservations, or groups of counties or reservations which have the same payment rate under this subdivision, and to the group of counties or reservations which are not certified providers under section 256F.10. The commissioner shall modify the requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.

Sec. 19. Minnesota Statutes 2020, section 256B.0943, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed emotional disturbance, as defined in section 245.4871, subdivision 15, or a diagnosed mental illness, as defined in section 245.462, subdivision 20. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility

for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.

(c) "Clinical trainee" means a mental health practitioner who meets the qualifications specified in Minnesota Rules, part 9505.0371, subpart 5, item C.

(d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a. Crisis assistance entails the development of a written plan to assist a child's family to contend with a potential crisis and is distinct from the immediate provision of crisis intervention services.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

(f) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for three or more individuals and individual or group skills training provided by a multidisciplinary team, under the clinical supervision of a mental health professional.

(g) "Diagnostic assessment" has the meaning given in Minnesota Rules, part 9505.0372, subpart 1.

(h) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered ~~telemedicine~~ services through telehealth as defined under section 256B.0625, subdivision 3b. Direct service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

(i) "Direction of mental health behavioral aide" means the activities of a mental health professional or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

(j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.

(k) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or mental health practitioner, under the clinical supervision of a mental health professional, to guide the work of the mental health behavioral aide. The individual behavioral plan may be incorporated into the child's individual treatment plan so long as the behavioral plan is separately communicable to the mental health behavioral aide.

(l) "Individual treatment plan" has the meaning given in Minnesota Rules, part 9505.0371, subpart 7.

(m) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a trained paraprofessional qualified as provided in subdivision 7, paragraph (b), clause (3), to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(n) "Mental health practitioner" has the meaning given in section 245.462, subdivision 17, except that a practitioner working in a day treatment setting may qualify as a mental health practitioner if the practitioner holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university, and: (1) has at least 2,000 hours of clinically supervised experience in the delivery of mental health services to clients with mental illness; (2) is fluent in the language, other than English, of the cultural group that makes up at least 50 percent of the practitioner's clients, completes 40 hours of training on the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once per week until meeting the required 2,000 hours of supervised experience; or (3) receives 40 hours of training on the delivery of services to clients with mental illness within six months of employment, and clinical supervision from a mental health professional at least once per week until meeting the required 2,000 hours of supervised experience.

(o) "Mental health professional" means an individual as defined in Minnesota Rules, part 9505.0370, subpart 18.

(p) "Mental health service plan development" includes:

(1) the development, review, and revision of a child's individual treatment plan, as provided in Minnesota Rules, part 9505.0371, subpart 7, including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health

services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) administering standardized outcome measurement instruments, determined and updated by the commissioner, as periodically needed to evaluate the effectiveness of treatment for children receiving clinical services and reporting outcome measures, as required by the commissioner.

(q) "Mental illness," for persons at least age 18 but under age 21, has the meaning given in section 245.462, subdivision 20, paragraph (a).

(r) "Psychotherapy" means the treatment of mental or emotional disorders or maladjustment by psychological means. Psychotherapy may be provided in many modalities in accordance with Minnesota Rules, part 9505.0372, subpart 6, including patient and/or family psychotherapy; family psychotherapy; psychotherapy for crisis; group psychotherapy; or multiple-family psychotherapy. Beginning with the American Medical Association's Current Procedural Terminology, standard edition, 2014, the procedure "individual psychotherapy" is replaced with "patient and/or family psychotherapy," a substantive change that permits the therapist to work with the client's family without the client present to obtain information about the client or to explain the client's treatment plan to the family. Psychotherapy is appropriate for crisis response when a child has become dysregulated or experienced new trauma since the diagnostic assessment was completed and needs psychotherapy to address issues not currently included in the child's individual treatment plan.

(s) "Rehabilitative services" or "psychiatric rehabilitation services" means a series or multidisciplinary combination of psychiatric and psychosocial interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement. Continuing progress toward goals is expected, and rehabilitative potential ceases when successive improvement is not observable over a period of time.

(t) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of

psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

Sec. 20. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team must use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) Services must be age-appropriate and meet the specific needs of the client.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every six months or prior to discharge from the service, whichever comes first.

(e) An individual treatment plan must:

(1) be based on the information in the client's diagnostic assessment and baselines;

(2) identify goals and objectives of treatment, a treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;

(3) be developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;

(4) be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessments, and treatment planning;

(5) be reviewed at least once every six months and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment;

(6) be signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's

parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;

(7) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan;

(8) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports;

(ii) be reviewed at least once every 90 days and revised, if necessary;

(9) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and

(10) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.

(f) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(g) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in

the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(h) The treatment team shall provide interventions to promote positive interpersonal relationships.

(i) The services and responsibilities of the psychiatric provider may be provided through telehealth as defined under section 256B.0625, subdivision 3b, when necessary to prevent disruption in client services or to maintain the required psychiatric staffing level.

Sec. 21. Minnesota Statutes 2020, section 256B.0949, subdivision 13, is amended to read:

Subd. 13. **Covered services.** (a) The services described in paragraphs (b) to (l) are eligible for reimbursement by medical assistance under this section. Services must be provided by a qualified EIDBI provider and supervised by a QSP. An EIDBI service must address the person's medically necessary treatment goals and must be targeted to develop, enhance, or maintain the individual developmental skills of a person with ASD or a related condition to improve functional communication, including nonverbal or social communication, social or interpersonal interaction, restrictive or repetitive behaviors, hyperreactivity or hyporeactivity to sensory input, behavioral challenges and self-regulation, cognition, learning and play, self-care, and safety.

(b) EIDBI treatment must be delivered consistent with the standards of an approved modality, as published by the commissioner. EIDBI modalities include:

(1) applied behavior analysis (ABA);

(2) developmental individual-difference relationship-based model (DIR/Floortime);

(3) early start Denver model (ESDM);

(4) PLAY project;

(5) relationship development intervention (RDI); or

(6) additional modalities not listed in clauses (1) to (5) upon approval by the commissioner.

(c) An EIDBI provider may use one or more of the EIDBI modalities in paragraph (b), clauses (1) to (5), as the primary modality for treatment as a covered service, or several EIDBI modalities in combination as the primary modality of treatment, as approved by the commissioner. An EIDBI provider that identifies and provides assurance of qualifications

for a single specific treatment modality must document the required qualifications to meet fidelity to the specific model.

(d) Each qualified EIDBI provider must identify and provide assurance of qualifications for professional licensure certification, or training in evidence-based treatment methods, and must document the required qualifications outlined in subdivision 15 in a manner determined by the commissioner.

(e) CMDE is a comprehensive evaluation of the person's developmental status to determine medical necessity for EIDBI services and meets the requirements of subdivision 5. The services must be provided by a qualified CMDE provider.

(f) EIDBI intervention observation and direction is the clinical direction and oversight of EIDBI services by the QSP, level I treatment provider, or level II treatment provider, including developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for the direct benefit of a person. EIDBI intervention observation and direction informs any modification of the current treatment protocol to support the outcomes outlined in the ITP.

(g) Intervention is medically necessary direct treatment provided to a person with ASD or a related condition as outlined in their ITP. All intervention services must be provided under the direction of a QSP. Intervention may take place across multiple settings. The frequency and intensity of intervention services are provided based on the number of treatment goals, person and family or caregiver preferences, and other factors. Intervention services may be provided individually or in a group. Intervention with a higher provider ratio may occur when deemed medically necessary through the person's ITP.

(1) Individual intervention is treatment by protocol administered by a single qualified EIDBI provider delivered ~~face-to-face~~ to one person.

(2) Group intervention is treatment by protocol provided by one or more qualified EIDBI providers, delivered to at least two people who receive EIDBI services.

(h) ITP development and ITP progress monitoring is development of the initial, annual, and progress monitoring of an ITP. ITP development and ITP progress monitoring documents provide oversight and ongoing evaluation of a person's treatment and progress on targeted goals and objectives and integrate and coordinate the person's and the person's legal representative's information from the CMDE and ITP progress monitoring. This service must be reviewed and completed by the QSP, and may include input from a level I provider or a level II provider.

(i) Family caregiver training and counseling is specialized training and education for a family or primary caregiver to understand the person's developmental status and help with the person's needs and development. This service must be provided by the QSP, level I provider, or level II provider.

(j) A coordinated care conference is a voluntary ~~face-to-face~~ meeting with the person and the person's family to review the CMDE or ITP progress monitoring and to integrate and coordinate services across providers and service-delivery systems to develop the ITP. This service must be provided by the QSP and may include the CMDE provider or a level I provider or a level II provider.

(k) Travel time is allowable billing for traveling to and from the person's home, school, a community setting, or place of service outside of an EIDBI center, clinic, or office from a specified location to provide ~~face-to-face~~ in-person EIDBI intervention, observation and direction, or family caregiver training and counseling. The person's ITP must specify the reasons the provider must travel to the person.

(l) Medical assistance covers medically necessary EIDBI services and consultations delivered by a licensed health care provider via ~~telemedicine~~ telehealth, as defined under section 256B.0625, subdivision 3b, in the same manner as if the service or consultation was delivered in person.

Sec. 22. **COMMISSIONER OF HUMAN SERVICES; EXTENSION OF COVID-19 HUMAN SERVICES PROGRAM MODIFICATIONS.**

Notwithstanding Laws 2020, First Special Session chapter 7, section 1, subdivision 2, as amended by Laws 2020, First Special Session chapter 1, section 3, when the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, the following modifications issued by the commissioner of human services pursuant to Executive Orders 20-11 and 20-12, and including any amendments to the modification issued before the peacetime emergency expires, shall remain in effect until June 30, 2023:

(1) CV16: expanding access to telemedicine services for Children's Health Insurance Program, Medical Assistance, and MinnesotaCare enrollees;

(2) CV21: allowing telemedicine alternative for school-linked mental health services and intermediate school district mental health services;

(3) CV24: allowing phone or video use for targeted case management visits;

(4) CV30: expanding telemedicine in health care, mental health, and substance use disorder settings; and

(5) CV45: permitting comprehensive assessments to be completed by telephone or video communication and permitting a counselor, recovery peer, or treatment coordinator to provide treatment services from their home by telephone or video communication to a client in their home.

Sec. 23. **EXPANDING TELEHEALTH DELIVERY OPTIONS STUDY.**

The commissioner of human services, in consultation with enrollees, providers, and other interested stakeholders, shall study the viability of the use of audio-only communication as a permitted option for delivering services through telehealth within the public health care programs. The study shall examine the use of audio-only communication in supporting equitable access to health care services, including behavioral health services for the elderly, rural communities, and communities of color, and eliminating barriers for vulnerable and underserved populations. The commissioner shall submit recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finances, by December 15, 2022.

Sec. 24. **STUDY OF TELEHEALTH.**

(a) The commissioner of health, in consultation with the commissioner of human services, shall study the impact of telehealth payment methodologies and expansion under this act on the coverage and provision of telehealth services under public health care programs and private health insurance. The study shall review:

(1) the impacts of telehealth payment methodologies and expansion on access to health care services, quality of care, and value-based payments and innovation in care delivery;

(2) the short-term and long-term impacts of telehealth payment methodologies and expansion in reducing health care disparities and providing equitable access for underserved communities;

(3) the short-term and long-term impacts, especially in rural areas, on access to and the availability of in-person care and specialty care, due to an expansion in the use of and investment in telehealth to deliver health care services;

(4) the criteria used for determining whether delivering a service by telehealth is medically appropriate to the condition and to the needs of the person receiving the services;

(5) the methods used to ensure that the rights of the patient to choose between receiving a service through telehealth or in-person are respected; and

(6) and make recommendations on interstate licensing options for health care professionals by reviewing advances in the delivery of health care through interstate telehealth while ensuring the safety and health of patients.

(b) In conducting the study, the commissioner shall consult with stakeholders and communities impacted by telehealth payment and expansion. The commissioner, notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, may use data available under that section to conduct the study. The commissioner shall report findings to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and commerce, by February 15, 2024.

Sec. 25. **TASK FORCE ON A PUBLIC-PRIVATE TELEPRESENCE STRATEGY.**

Subdivision 1. **Membership.** (a) The task force on person-centered telepresence platform strategy consists of the following 20 members:

(1) two senators, one appointed by the majority leader of the senate and one appointed by the minority leader of the senate;

(2) two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives;

(3) two members appointed by the Association of Minnesota Counties representing county services in the areas of human services, public health, and corrections or law enforcement. One of these members must represent counties outside the metropolitan area defined in Minnesota Statutes, section 473.121, and one of these members must represent the metropolitan area defined in Minnesota Statutes, section 473.121;

(4) one member appointed by the Minnesota American Indian Mental Health Advisory Council;

(5) one member appointed by the Minnesota Medical Association who is a primary care provider practicing in Minnesota;

(6) one member appointed by the NAMI of Minnesota;

(7) one member appointed by the Minnesota School Boards Association;

(8) one member appointed by the Minnesota Hospital Association to represent hospital emergency departments;

(9) one member appointed by the Minnesota Association of Community Mental Health Programs to represent rural community mental health centers;

(10) one member appointed by the Council of Health Plans;

(11) one member from a rural nonprofit foundation with expertise in delivering health and human services via broadband, appointed by the Blandin Foundation;

(12) one member representing child advocacy centers, appointed by the Minnesota Social Service Association;

(13) one member appointed by the Minnesota Social Service Association;

(14) one member appointed by the Medical Alley Association;

(15) one member appointed by the Minnesota Nurses Association;

(16) one member appointed by the chief justice of the supreme court; and

(17) the state public defender or a designee.

(b) In addition to the members identified in paragraph (a), the task force shall include the following members as ex officio, nonvoting members:

(1) the commissioner of corrections or a designee;

(2) the commissioner of human services or a designee;

(3) the commissioner of health or a designee; and

(4) the commissioner of education or a designee.

Subd. 2. **Appointment deadline; first meeting; chair.** Appointing authorities must complete appointments by June 15, 2021. The task force shall select a chair from among their members at their first meeting. The member appointed by the senate majority leader shall convene the first meeting of the task force by July 15, 2021.

Subd. 3. **Duties.** The task force shall:

(1) explore opportunities for improving behavioral health and other health care service delivery through the use of a common interoperable person-centered telepresence platform that provides HIPAA compliant connectivity and technical support to potential users;

(2) review and coordinate state and local innovation initiatives and investments designed to leverage telepresence connectivity and collaboration for Minnesotans;

(3) determine standards for a single interoperable telepresence platform;

(4) determine statewide capabilities for a single interoperable telepresence platform;

(5) identify barriers to providing a telepresence technology, including limited availability of bandwidth, limitations in providing certain services via telepresence, and broadband infrastructure needs;

(6) identify and make recommendations for governance that will assure person-centered responsiveness;

(7) identify how the business model can be innovated to provide an incentive for ongoing innovation in Minnesota's health care, human services, education, corrections, and related ecosystems;

(8) identify criteria for suggested deliverables including:

(i) equitable statewide access;

(ii) evaluating bandwidth availability; and

(iii) competitive pricing;

(9) identify sustainable financial support for a single telepresence platform, including infrastructure costs startup costs for potential users;

(10) identify the benefits to partners in the private sector, state, political subdivisions, tribal governments, and the constituents they serve in using a common person-centered telepresence platform for delivering behavioral health services; and

(11) consult with members of communities who are likely to use a common person-centered telepresence platform, including communities of color, the disability community, and other underserved communities.

Subd. 4. **Administrative support.** The Legislative Coordinating Commission shall provide administrative support to the task force. The Legislative Coordinating Commission may provide meeting space or may use space provided by the Minnesota Social Service Association for meetings.

Subd. 5. **Per diem; expenses.** Public members of the task force may be compensated and have their expenses reimbursed as provided in Minnesota Statutes, section 15.059, subdivision 3.

Subd. 6. **Report.** The task force shall report to the chairs and ranking minority members of the committees in the senate and the house of representatives with primary jurisdiction over health and state information technology by January 15, 2022, with recommendations related to expanding the state's telepresence platform and any legislation required to implement the recommendations.

Subd. 7. **Expiration.** The task force expires July 31, 2022, or the day after the task force submits the report required in this section, whichever is earlier.

Sec. 26. **REVISOR INSTRUCTION.**

In Minnesota Statutes and Minnesota Rules, the revisor of statutes shall substitute the term "telemedicine" with "telehealth" whenever the term appears and substitute Minnesota Statutes, section 62A.673, whenever references to Minnesota Statutes, sections 62A.67, 62A.671, and 62A.672 appear.

Sec. 27. **REPEALER.**

Minnesota Statutes 2020, sections 62A.67; 62A.671; 62A.672; 256B.0596; and 256B.0924, subdivision 4a, are repealed.

No active language found for: 62A.67

No active language found for: 62A.671

No active language found for: 62A.672

No active language found for: 256B.0596

256B.0924 TARGETED CASE MANAGEMENT SERVICES.

Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment under subdivision 6 if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contact.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;

(3) established protocols addressing how and when to discontinue interactive video services; and

(4) established a quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video:

(1) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the person receiving case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized;

(4) the location of the originating site and the distant site; and

(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).