

ARTICLE 7

TELEHEALTH

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 the 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 transfer" means the asynchronous electronic transfer 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 transfers, 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

ARTICLE 8

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(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 technology, 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 transfer or transmission 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

322.29 of care for the service can be met through the use of audio-only communication. Telehealth
 322.30 does not include communication between health care providers or between a health care
 322.31 provider and a patient that consists solely of an e-mail or facsimile transmission. Telehealth
 322.32 does not include communication between health care providers that consists solely of a
 322.33 telephone conversation.

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

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

323.9 (b) Coverage for services delivered through telehealth must not be limited on the basis
 323.10 of geography, location, or distance for travel.

323.11 (c) A health carrier must not create a separate provider network or provide incentives
 323.12 to enrollees to use a separate provider network to deliver services through telehealth that
 323.13 does not include network providers who provide in-person care to patients for the same
 323.14 service.

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

323.19 (e) Nothing in this section:

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

323.22 (2) prohibits a health carrier from:

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

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

216.14 of care for the service can be met through the use of audio-only communication. Telehealth
 216.15 does not include communication between health care providers or between a health care
 216.16 provider and a patient that consists solely of an e-mail or facsimile transmission. Telehealth
 216.17 does not include communication between health care providers that consists solely of a
 216.18 telephone conversation. Telehealth does not include telemonitoring services as defined in
 216.19 paragraph (i).

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

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

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

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

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

217.5 (e) Nothing in this section:

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

217.8 (2) prohibits a health carrier from:

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

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

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

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

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

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

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

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

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

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

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

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

324.30 **Subd. 6. Telehealth equipment.** (a) A health carrier must not require a health care
 324.31 provider to use specific telecommunications technology and equipment as a condition of
 324.32 coverage under this section, provided the health care provider uses telecommunications

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

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

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

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

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

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

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

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

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

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

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

218.18 **Subd. 6. Telehealth equipment.** (a) A health carrier must not require a health care
 218.19 provider to use specific telecommunications technology and equipment as a condition of
 218.20 coverage under this section, provided the health care provider uses telecommunications

324.33 technology and equipment that complies with current industry interoperable standards and
 325.1 complies with standards required under the federal Health Insurance Portability and
 325.2 Accountability Act of 1996, Public Law 104-191, and regulations promulgated under that
 325.3 Act, unless authorized under this section.

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

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

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

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

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

325.17 **EFFECTIVE DATE.** This section is effective January 1, 2022.

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

325.19 **147.033 PRACTICE OF ~~TELEMEDICINE~~ TELEHEALTH.**

325.20 Subdivision 1. **Definition.** ~~For the purposes of this section, "telemedicine" means the~~
 325.21 ~~delivery of health care services or consultations while the patient is at an originating site~~
 325.22 ~~and the licensed health care provider is at a distant site. A communication between licensed~~
 325.23 ~~health care providers that consists solely of a telephone conversation, e-mail, or facsimile~~
 325.24 ~~transmission does not constitute telemedicine consultations or services. A communication~~
 325.25 ~~between a licensed health care provider and a patient that consists solely of an e-mail or~~
 325.26 ~~facsimile transmission does not constitute telemedicine consultations or services.~~
 325.27 ~~Telemedicine may be provided by means of real-time two-way interactive audio, and visual~~
 325.28 ~~communications, including the application of secure video conferencing or store-and-forward~~
 325.29 ~~technology to provide or support health care delivery, that facilitate the assessment, diagnosis,~~

218.21 technology and equipment that complies with current industry interoperable standards and
 218.22 complies with standards required under the federal Health Insurance Portability and
 218.23 Accountability Act of 1996, Public Law 104-191, and regulations promulgated under that
 218.24 Act, unless authorized under this section.

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

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

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

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

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

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

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

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

219.13 **147.033 PRACTICE OF ~~TELEMEDICINE~~ TELEHEALTH.**

219.14 Subdivision 1. **Definition.** ~~For the purposes of this section, "telemedicine" means the~~
 219.15 ~~delivery of health care services or consultations while the patient is at an originating site~~
 219.16 ~~and the licensed health care provider is at a distant site. A communication between licensed~~
 219.17 ~~health care providers that consists solely of a telephone conversation, e-mail, or facsimile~~
 219.18 ~~transmission does not constitute telemedicine consultations or services. A communication~~
 219.19 ~~between a licensed health care provider and a patient that consists solely of an e-mail or~~
 219.20 ~~facsimile transmission does not constitute telemedicine consultations or services.~~
 219.21 ~~Telemedicine may be provided by means of real-time two-way interactive audio, and visual~~
 219.22 ~~communications, including the application of secure video conferencing or store-and-forward~~
 219.23 ~~technology to provide or support health care delivery, that facilitate the assessment, diagnosis,~~

325.30 ~~consultation, treatment, education, and care management of a patient's health care.~~
 325.31 "telehealth" has the meaning given in section 62A.673, subdivision 2, paragraph (h).

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

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

326.6 **EFFECTIVE DATE.** This section is effective January 1, 2022.

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

326.8 Subd. 2. **Prescribing and filing.** (a) A licensed practitioner in the course of professional
 326.9 practice only, may prescribe, administer, and dispense a legend drug, and may cause the
 326.10 same to be administered by a nurse, a physician assistant, or medical student or resident
 326.11 under the practitioner's direction and supervision, and may cause a person who is an
 326.12 appropriately certified, registered, or licensed health care professional to prescribe, dispense,
 326.13 and administer the same within the expressed legal scope of the person's practice as defined
 326.14 in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference
 326.15 to a specific patient, by directing a licensed dietitian or licensed nutritionist, pursuant to
 326.16 section 148.634; a nurse, pursuant to section 148.235, subdivisions 8 and 9; physician
 326.17 assistant; medical student or resident; or pharmacist according to section 151.01, subdivision
 326.18 27, to adhere to a particular practice guideline or protocol when treating patients whose
 326.19 condition falls within such guideline or protocol, and when such guideline or protocol
 326.20 specifies the circumstances under which the legend drug is to be prescribed and administered.
 326.21 An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic
 326.22 order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug.
 326.23 This paragraph applies to a physician assistant only if the physician assistant meets the
 326.24 requirements of ~~section 147A.18~~ sections 147A.02 and 147A.09.

326.25 (b) The commissioner of health, if a licensed practitioner, or a person designated by the
 326.26 commissioner who is a licensed practitioner, may prescribe a legend drug to an individual
 326.27 or by protocol for mass dispensing purposes where the commissioner finds that the conditions
 326.28 triggering section 144.4197 or 144.4198, subdivision 2, paragraph (b), exist. The
 326.29 commissioner, if a licensed practitioner, or a designated licensed practitioner, may prescribe,
 326.30 dispense, or administer a legend drug or other substance listed in subdivision 10 to control
 326.31 tuberculosis and other communicable diseases. The commissioner may modify state drug
 326.32 labeling requirements, and medical screening criteria and documentation, where time is
 326.33 critical and limited labeling and screening are most likely to ensure legend drugs reach the
 326.34 maximum number of persons in a timely fashion so as to reduce morbidity and mortality.

327.1 (c) A licensed practitioner that dispenses for profit a legend drug that is to be administered
 327.2 orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the
 327.3 practitioner's licensing board a statement indicating that the practitioner dispenses legend

219.24 ~~consultation, treatment, education, and care management of a patient's health care.~~
 219.25 "telehealth" has the meaning given in section 62A.673, subdivision 2, paragraph (h).

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

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

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

220.2 Subd. 2. **Prescribing and filing.** (a) A licensed practitioner in the course of professional
 220.3 practice only, may prescribe, administer, and dispense a legend drug, and may cause the
 220.4 same to be administered by a nurse, a physician assistant, or medical student or resident
 220.5 under the practitioner's direction and supervision, and may cause a person who is an
 220.6 appropriately certified, registered, or licensed health care professional to prescribe, dispense,
 220.7 and administer the same within the expressed legal scope of the person's practice as defined
 220.8 in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference
 220.9 to a specific patient, by directing a licensed dietitian or licensed nutritionist, pursuant to
 220.10 section 148.634; a nurse, pursuant to section 148.235, subdivisions 8 and 9; physician
 220.11 assistant; medical student or resident; or pharmacist according to section 151.01, subdivision
 220.12 27, to adhere to a particular practice guideline or protocol when treating patients whose
 220.13 condition falls within such guideline or protocol, and when such guideline or protocol
 220.14 specifies the circumstances under which the legend drug is to be prescribed and administered.
 220.15 An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic
 220.16 order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug.
 220.17 This paragraph applies to a physician assistant only if the physician assistant meets the
 220.18 requirements of ~~section 147A.18~~ sections 147A.02 and 147A.09.

220.19 (b) The commissioner of health, if a licensed practitioner, or a person designated by the
 220.20 commissioner who is a licensed practitioner, may prescribe a legend drug to an individual
 220.21 or by protocol for mass dispensing purposes where the commissioner finds that the conditions
 220.22 triggering section 144.4197 or 144.4198, subdivision 2, paragraph (b), exist. The
 220.23 commissioner, if a licensed practitioner, or a designated licensed practitioner, may prescribe,
 220.24 dispense, or administer a legend drug or other substance listed in subdivision 10 to control
 220.25 tuberculosis and other communicable diseases. The commissioner may modify state drug
 220.26 labeling requirements, and medical screening criteria and documentation, where time is
 220.27 critical and limited labeling and screening are most likely to ensure legend drugs reach the
 220.28 maximum number of persons in a timely fashion so as to reduce morbidity and mortality.

220.29 (c) A licensed practitioner that dispenses for profit a legend drug that is to be administered
 220.30 orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the
 220.31 practitioner's licensing board a statement indicating that the practitioner dispenses legend

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

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

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

327.23 (2) drugs defined by the Board of Pharmacy as controlled substances under section
 327.24 152.02, subdivisions 7, 8, and 12;

327.25 (3) muscle relaxants;

327.26 (4) centrally acting analgesics with opioid activity;

327.27 (5) drugs containing butalbital; or

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

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

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

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

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

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

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

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

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

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

221.16 (2) drugs defined by the Board of Pharmacy as controlled substances under section
 221.17 152.02, subdivisions 7, 8, and 12;

221.18 (3) muscle relaxants;

221.19 (4) centrally acting analgesics with opioid activity;

221.20 (5) drugs containing butalbital; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

329.8 **EFFECTIVE DATE.** This section is effective January 1, 2022.

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

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

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

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

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

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

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

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

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

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

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

329.10 Subd. 13. **Face-to-face.** "Face-to-face" means two-way, real-time, interactive ~~and visual~~
 329.11 communication between a client and a treatment service provider and includes services
 329.12 delivered in person or via ~~telemedicine~~ telehealth with priority being given to interactive
 329.13 audio and visual communication, if available. Meetings required by section 245G.22,
 329.14 subdivision 4, must be conducted by interactive video and visual communication.

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

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

329.19 Subd. 26. ~~**Telemedicine Telehealth.** "Telemedicine"~~ "Telehealth" means the delivery
 329.20 of a substance use disorder treatment service while the client is at an originating site and
 329.21 the ~~licensed~~ health care provider is at a distant site via telehealth as defined in section
 329.22 256B.0625, subdivision 3b, and as specified in section 254B.05, subdivision 5, paragraph
 329.23 (f).

329.24 **EFFECTIVE DATE.** This section is effective January 1, 2022.

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

329.26 Subdivision 1. **General.** Each client must have a person-centered individual treatment
 329.27 plan developed by an alcohol and drug counselor within ten days from the day of service
 329.28 initiation for a residential program and within five calendar days on which a treatment
 329.29 session has been provided from the day of service initiation for a client in a nonresidential
 329.30 program. Opioid treatment programs must complete the individual treatment plan within
 329.31 21 days from the day of service initiation. The individual treatment plan must be signed by
 330.1 the client and the alcohol and drug counselor and document the client's involvement in the
 330.2 development of the plan. The individual treatment plan is developed upon the qualified staff
 330.3 member's dated signature. Treatment planning must include ongoing assessment of client
 330.4 needs. An individual treatment plan must be updated based on new information gathered
 330.5 about the client's condition, the client's level of participation, and on whether methods
 330.6 identified have the intended effect. A change to the plan must be signed by the client and
 330.7 the alcohol and drug counselor. If the client chooses to have family or others involved in
 330.8 treatment services, the client's individual treatment plan must include how the family or
 330.9 others will be involved in the client's treatment. If a client is receiving treatment services
 330.10 or an assessment via telehealth and the ~~license holder~~ documents the reason the client's
 330.11 signature cannot be obtained, the alcohol and drug counselor may document the client's
 330.12 verbal approval or electronic written approval of the treatment plan or change to the treatment
 330.13 plan in lieu of the client's signature.

330.14 **EFFECTIVE DATE.** This section is effective January 1, 2022.

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

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

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

223.7 Subd. 26. ~~**Telemedicine Telehealth.** "Telemedicine"~~ "Telehealth" means the delivery
 223.8 of a substance use disorder treatment service while the client is at an originating site and
 223.9 the ~~licensed~~ health care provider is at a distant site via telehealth as defined in section
 223.10 256B.0625, subdivision 3b, and as specified in section 254B.05, subdivision 5, paragraph
 223.11 (f).

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

223.13 Subdivision 1. **General.** Each client must have a person-centered individual treatment
 223.14 plan developed by an alcohol and drug counselor within ten days from the day of service
 223.15 initiation for a residential program and within five calendar days on which a treatment
 223.16 session has been provided from the day of service initiation for a client in a nonresidential
 223.17 program. Opioid treatment programs must complete the individual treatment plan within
 223.18 21 days from the day of service initiation. The individual treatment plan must be signed by
 223.19 the client and the alcohol and drug counselor and document the client's involvement in the
 223.20 development of the plan. The individual treatment plan is developed upon the qualified staff
 223.21 member's dated signature. Treatment planning must include ongoing assessment of client
 223.22 needs. An individual treatment plan must be updated based on new information gathered
 223.23 about the client's condition, the client's level of participation, and on whether methods
 223.24 identified have the intended effect. A change to the plan must be signed by the client and
 223.25 the alcohol and drug counselor. If the client chooses to have family or others involved in
 223.26 treatment services, the client's individual treatment plan must include how the family or
 223.27 others will be involved in the client's treatment. If a client is receiving treatment services
 223.28 or an assessment via telehealth and the ~~alcohol and drug counselor~~ documents the reason
 223.29 the client's signature cannot be obtained, the alcohol and drug counselor may document the
 223.30 client's verbal approval of the treatment plan or change to the treatment plan in lieu of the
 223.31 client's signature.

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

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

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

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

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

330.25 (b) Eligible substance use disorder treatment services include:

330.26 (1) outpatient treatment services that are licensed according to sections 245G.01 to
330.27 245G.17, or applicable tribal license;

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

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

331.1 (4) peer recovery support services provided according to section 245G.07, subdivision
331.2 2, clause (8);

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

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

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

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

331.12 (9) hospital-based treatment services that are licensed according to sections 245G.01 to
331.13 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to
331.14 144.56;

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

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

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

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

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

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

224.11 (b) Eligible substance use disorder treatment services include:

224.12 (1) outpatient treatment services that are licensed according to sections 245G.01 to
224.13 245G.17, or applicable tribal license;

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

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

224.18 (4) peer recovery support services provided according to section 245G.07, subdivision
224.19 2, clause (8);

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

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

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

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

224.29 (9) hospital-based treatment services that are licensed according to sections 245G.01 to
224.30 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to
224.31 144.56;

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

331.19 (11) high-intensity residential treatment services that are licensed according to sections
331.20 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of
331.21 clinical services each week provided by a state-operated vendor or to clients who have been
331.22 civilly committed to the commissioner, present the most complex and difficult care needs,
331.23 and are a potential threat to the community; and

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

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

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

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

331.29 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
331.30 9503; or

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

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

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

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

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

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

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

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

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

225.5 (11) high-intensity residential treatment services that are licensed according to sections
225.6 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of
225.7 clinical services each week provided by a state-operated vendor or to clients who have been
225.8 civilly committed to the commissioner, present the most complex and difficult care needs,
225.9 and are a potential threat to the community; and

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

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

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

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

225.15 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
225.16 9503; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

333.23 (g) For the purpose of reimbursement under this section, substance use disorder treatment
 333.24 services provided in a group setting without a group participant maximum or maximum
 333.25 client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one.
 333.26 At least one of the attending staff must meet the qualifications as established under this

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

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

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

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

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

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

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

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

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

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

227.8 (g) For the purpose of reimbursement under this section, substance use disorder treatment
 227.9 services provided in a group setting without a group participant maximum or maximum
 227.10 client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one.
 227.11 At least one of the attending staff must meet the qualifications as established under this

333.27 chapter for the type of treatment service provided. A recovery peer may not be included as
 333.28 part of the staff ratio.

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

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

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

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

334.8 (i) 180 days preceding an eligible recipient's discharge from an institution; or
 334.9 (ii) the limits and conditions which apply to federal Medicaid funding for this service;

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

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

334.14 EFFECTIVE DATE. This section is effective upon federal approval. The commissioner
 334.15 of human services shall notify the revisor of statutes when federal approval is obtained.

227.12 chapter for the type of treatment service provided. A recovery peer may not be included as
 227.13 part of the staff ratio.

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

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

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

227.21 (i) 180 days preceding an eligible recipient's discharge from an institution; or
 227.22 (ii) the limits and conditions which apply to federal Medicaid funding for this service;

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

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

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

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

227.30 (1) the team leader:

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

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

228.7 (iii) must be a single full-time staff member, dedicated to the ACT team, who is
 228.8 responsible for overseeing the administrative operations of the team, providing clinical

- 228.9 oversight of services in conjunction with the psychiatrist or psychiatric care provider, and
 228.10 supervising team members to ensure delivery of best and ethical practices; and
- 228.11 (iv) must be available to provide overall clinical oversight to the ACT team after regular
 228.12 business hours and on weekends and holidays. The team leader may delegate this duty to
 228.13 another qualified member of the ACT team;
- 228.14 (2) the psychiatric care provider:
- 228.15 (i) must be a licensed psychiatrist certified by the American Board of Psychiatry and
 228.16 Neurology or eligible for board certification or certified by the American Osteopathic Board
 228.17 of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who
 228.18 is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A. The psychiatric care
 228.19 provider must have demonstrated clinical experience working with individuals with serious
 228.20 and persistent mental illness;
- 228.21 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for
 228.22 screening and admitting clients; monitoring clients' treatment and team member service
 228.23 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,
 228.24 and health-related conditions; actively collaborating with nurses; and helping provide clinical
 228.25 supervision to the team;
- 228.26 (iii) shall fulfill the following functions for assertive community treatment clients:
 228.27 provide assessment and treatment of clients' symptoms and response to medications, including
 228.28 side effects; provide brief therapy to clients; provide diagnostic and medication education
 228.29 to clients, with medication decisions based on shared decision making; monitor clients'
 228.30 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and
 228.31 community visits;
- 229.1 (iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized
 229.2 for mental health treatment and shall communicate directly with the client's inpatient
 229.3 psychiatric care providers to ensure continuity of care;
- 229.4 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
 229.5 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
 229.6 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
 229.7 supervisory, and administrative responsibilities. No more than two psychiatric care providers
 229.8 may share this role;
- 229.9 (vi) may not provide specific roles and responsibilities by telemedicine unless approved
 229.10 by the commissioner services through telehealth as defined under section 256B.0625,
 229.11 subdivision 3b, when necessary to ensure the continuation of psychiatric and medication
 229.12 services availability for clients and to maintain statutory requirements for psychiatric care
 229.13 provider staffing levels; and

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

229.17 (3) the nursing staff:

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

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

229.24 (iii) shall develop strategies, in collaboration with clients, to maximize taking medications
229.25 as prescribed; screen and monitor clients' mental and physical health conditions and
229.26 medication side effects; engage in health promotion, prevention, and education activities;
229.27 communicate and coordinate services with other medical providers; facilitate the development
229.28 of the individual treatment plan for clients assigned; and educate the ACT team in monitoring
229.29 psychiatric and physical health symptoms and medication side effects;

229.30 (4) the co-occurring disorder specialist:

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

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

230.11 (5) the vocational specialist:

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

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

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

230.22 (6) the mental health certified peer specialist:

230.23 (i) shall be a full-time equivalent mental health certified peer specialist as defined in
230.24 section 256B.0615. No more than two individuals can share this position. The mental health
230.25 certified peer specialist is a fully integrated team member who provides highly individualized
230.26 services in the community and promotes the self-determination and shared decision-making
230.27 abilities of clients. This requirement may be waived due to workforce shortages upon
230.28 approval of the commissioner;

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

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

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

231.6 (8) additional staff:

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

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

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

231.17 (c) Each ACT team member must serve as a primary team member for clients assigned
231.18 by the team leader and are responsible for facilitating the individual treatment plan process
231.19 for those clients. The primary team member for a client is the responsible team member
231.20 knowledgeable about the client's life and circumstances and writes the individual treatment

334.16 Sec. 10. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, is amended to read:

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

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

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

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

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

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

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

335.7 (c) As a condition of payment, a licensed health care provider must document each
335.8 occurrence of a health service ~~provided by telemedicine delivered through telehealth~~ to a
335.9 medical assistance enrollee. Health care service records for services ~~provided by telemedicine~~
335.10 delivered through telehealth must meet the requirements set forth in Minnesota Rules, part
335.11 9505.2175, subparts 1 and 2, and must document:

231.21 plan. The primary team member provides individual supportive therapy or counseling, and
231.22 provides primary support and education to the client's family and support system.

231.23 (d) Members of the ACT team must have strong clinical skills, professional qualifications,
231.24 experience, and competency to provide a full breadth of rehabilitation services. Each staff
231.25 member shall be proficient in their respective discipline and be able to work collaboratively
231.26 as a member of a multidisciplinary team to deliver the majority of the treatment,
231.27 rehabilitation, and support services clients require to fully benefit from receiving assertive
231.28 community treatment.

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

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

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

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

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

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

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

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

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

232.22 (c) As a condition of payment, a licensed health care provider must document each
232.23 occurrence of a health service ~~provided by telemedicine delivered through telehealth~~ to a
232.24 medical assistance enrollee. Health care service records for services ~~provided by telemedicine~~
232.25 delivered through telehealth must meet the requirements set forth in Minnesota Rules, part
232.26 9505.2175, subparts 1 and 2, and must document:

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

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

335.14 designation;

335.15 (3) the ~~licensed~~ health care provider's basis for determining that ~~telemedicine~~ telehealth

335.16 is an appropriate and effective means for delivering the service to the enrollee;

335.17 (4) the mode of transmission ~~of used to deliver the telemedicine service~~ through telehealth

335.18 and records evidencing that a particular mode of transmission was utilized;

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

335.20 (6) if the claim for payment is based on a physician's ~~telemedicine~~ consultation with

335.21 another physician through telehealth, the written opinion from the consulting physician

335.22 providing the ~~telemedicine~~ telehealth consultation; and

335.23 (7) compliance with the criteria attested to by the health care provider in accordance

335.24 with paragraph (b).

335.25 ~~(d) For purposes of this subdivision, unless otherwise covered under this chapter;~~

335.26 ~~"telemedicine" is defined as the delivery of health care services or consultations while the~~

335.27 ~~patient is at an originating site and the licensed health care provider is at a distant site. A~~

335.28 ~~communication between licensed health care providers, or a licensed health care provider~~

335.29 ~~and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission~~

335.30 ~~does not constitute telemedicine consultations or services. Telemedicine may be provided~~

335.31 ~~by means of real-time two-way, interactive audio and visual communications, including the~~

335.32 ~~application of secure video conferencing or store-and-forward technology to provide or~~

336.1 ~~support health care delivery, which facilitate the assessment, diagnosis, consultation,~~

336.2 ~~treatment, education, and care management of a patient's health care.;~~

336.3 (1) "telehealth" means the delivery of health care services or consultations through the

336.4 use of real-time, two-way interactive audio and visual or audio-only communications to

336.5 provide or support health care delivery and facilitate the assessment, diagnosis, consultation,

336.6 treatment, education, and care management of a patient's health care. Telehealth includes

336.7 the application of secure video conferencing, store-and-forward transfers, and synchronous

336.8 interactions between a patient located at an originating site and a health care provider located

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

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

232.29 designation;

232.30 (3) the ~~licensed~~ health care provider's basis for determining that ~~telemedicine~~ telehealth

232.31 is an appropriate and effective means for delivering the service to the enrollee;

233.1 (4) the mode of transmission ~~of used to deliver the telemedicine service~~ through telehealth

233.2 and records evidencing that a particular mode of transmission was utilized;

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

233.4 (6) if the claim for payment is based on a physician's ~~telemedicine~~ consultation with

233.5 another physician through telehealth, the written opinion from the consulting physician

233.6 providing the ~~telemedicine~~ telehealth consultation; and

233.7 (7) compliance with the criteria attested to by the health care provider in accordance

233.8 with paragraph (b).

233.9 (d) Telehealth visits, as described in this subdivision provided through audio and visual

233.10 communication, may be used to satisfy the face-to-face requirement for reimbursement

233.11 under the payment methods that apply to a federally qualified health center, rural health

233.12 clinic, Indian health service, 638 tribal clinic, and certified community behavioral health

233.13 clinic, if the service would have otherwise qualified for payment if performed in person.

233.14 (e) For mental health services or assessments delivered through telehealth that are based

233.15 on an individual treatment plan, the provider may document the client's verbal approval of

233.16 the treatment plan or change in the treatment plan in lieu of the client's signature in

233.17 accordance with Minnesota Rules, part 9505.0371.

233.18 ~~(f) For purposes of this subdivision, unless otherwise covered under this chapter;~~

233.19 ~~"telemedicine" is defined as the delivery of health care services or consultations while the~~

233.20 ~~patient is at an originating site and the licensed health care provider is at a distant site. A~~

233.21 ~~communication between licensed health care providers, or a licensed health care provider~~

233.22 ~~and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission~~

233.23 ~~does not constitute telemedicine consultations or services. Telemedicine may be provided~~

233.24 ~~by means of real-time two-way, interactive audio and visual communications, including the~~

233.25 ~~application of secure video conferencing or store-and-forward technology to provide or~~

233.26 ~~support health care delivery, which facilitate the assessment, diagnosis, consultation,~~

233.27 ~~treatment, education, and care management of a patient's health care.;~~

233.28 (1) "telehealth" means the delivery of health care services or consultations through the

233.29 use of real time two-way interactive audio and visual communication to provide or support

233.30 health care delivery and facilitate the assessment, diagnosis, consultation, treatment,

233.31 education, and care management of a patient's health care. Telehealth includes the application

233.32 of secure video conferencing, store-and-forward technology, and synchronous interactions

233.33 between a patient located at an originating site and a health care provider located at a distant

336.9 at a distant site. Unless interactive visual and audio communication is specifically required,
 336.10 telehealth includes audio-only communication between a health care provider and a patient,
 336.11 if the communication is a scheduled appointment with the health care provider and the
 336.12 standard of care for the service can be met through the use of audio-only communication.
 336.13 Telehealth does not include communication between health care providers, or communication
 336.14 between a health care provider and a patient that consists solely of an e-mail or facsimile
 336.15 transmission;

336.16 (e) For purposes of this section, "licensed (2) "health care provider" means a licensed
 336.17 health care provider under section 62A.671, subdivision 6 as defined under section 62A.673,
 336.18 a community paramedic as defined under section 144E.001, subdivision 5f, ~~or a mental~~
 336.19 ~~health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision~~
 336.20 ~~26, working under the general supervision of a mental health professional, and a community~~
 336.21 ~~health worker who meets the criteria under subdivision 49, paragraph (a); "health care~~
 336.22 ~~provider" is defined under section 62A.671, subdivision 3; a mental health certified peer~~
 336.23 ~~specialist under section 256B.0615, subdivision 5, a mental health certified family peer~~
 336.24 ~~specialist under section 256B.0616, subdivision 5, a mental health rehabilitation worker~~
 336.25 ~~under section 256B.0623, subdivision 5, paragraph (a), clause (4), and paragraph (b), a~~
 336.26 ~~mental health behavioral aide under section 256B.0943, subdivision 7, paragraph (b), clause~~
 336.27 ~~(3), a treatment coordinator under section 245G.11, subdivision 7, an alcohol and drug~~
 336.28 ~~counselor under section 245G.11, subdivision 5, a recovery peer under section 245G.11,~~
 336.29 ~~subdivision 8, and a mental health case manager under section 245.462, subdivision 4; and~~

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

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

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

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

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

337.9 Sec. 11. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
 337.10 to read:

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

233.34 site. Telehealth does not include communication between health care providers or between
 234.1 a health care provider and a patient that consists solely of a audio-only communication , an
 234.2 e-mail, or facsimile transmission unless authorized by the commissioner or specified by
 234.3 law;

234.4 (e) For purposes of this section, "licensed (2) "health care provider" means a licensed
 234.5 health care provider under section 62A.671, subdivision 6 as defined under section 62A.673,
 234.6 a community paramedic as defined under section 144E.001, subdivision 5f, ~~or a mental~~
 234.7 ~~health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision~~
 234.8 ~~26, working under the general supervision of a mental health professional, and a community~~
 234.9 ~~health worker who meets the criteria under subdivision 49, paragraph (a); "health care~~
 234.10 ~~provider" is defined under section 62A.671, subdivision 3; a mental health certified peer~~
 234.11 ~~specialist under section 256B.0615, subdivision 5, a mental health certified family peer~~
 234.12 ~~specialist under section 256B.0616, subdivision 5, a mental health rehabilitation worker~~
 234.13 ~~under section 256B.0623, subdivision 5, paragraph (a), clause (4), and paragraph (b), a~~
 234.14 ~~mental health behavioral aide under section 256B.0943, subdivision 7, paragraph (b), clause~~
 234.15 ~~(3), a treatment coordinator under section 245G.11, subdivision 7, an alcohol and drug~~
 234.16 ~~counselor under section 245G.11, subdivision 5, a recovery peer under section 245G.11,~~
 234.17 ~~subdivision 8; and~~

234.18 (3) "originating site" is defined under section 62A.671, subdivision 7, "distant site," and
 234.19 "store-and-forward technology" have the meanings given in section 62A.673, subdivision
 234.20 2.

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

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

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

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

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

337.13 (1) has been diagnosed and is receiving services for at least one of the following chronic
 337.14 conditions: hypertension, cancer, congestive heart failure, chronic obstructive pulmonary
 337.15 disease, asthma, or diabetes;

337.16 (2) requires at least five times per week monitoring to manage the chronic condition, as
 337.17 ordered by the recipient's health care provider;

337.18 (3) has had two or more emergency room or inpatient hospitalization stays within the
 337.19 last 12 months due to the chronic condition or the recipient's health care provider has
 337.20 identified that telemonitoring services would likely prevent the recipient's admission or
 337.21 readmission to a hospital, emergency room, or nursing facility;

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

337.25 (5) resides in a setting that is suitable for telemonitoring and not in a setting that has
 337.26 health care staff on site.

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

338.3 **EFFECTIVE DATE.** This section is effective January 1, 2022.

338.4 Sec. 12. Minnesota Statutes 2020, section 256B.0625, subdivision 13h, is amended to
 338.5 read:

338.6 Subd. 13h. **Medication therapy management services.** (a) Medical assistance covers
 338.7 medication therapy management services for a recipient taking prescriptions to treat or
 338.8 prevent one or more chronic medical conditions. For purposes of this subdivision,
 338.9 "medication therapy management" means the provision of the following pharmaceutical

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

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

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

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

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

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

235.18 Subd. 13h. **Medication therapy management services.** (a) Medical assistance covers
 235.19 medication therapy management services for a recipient taking prescriptions to treat or
 235.20 prevent one or more chronic medical conditions. For purposes of this subdivision,
 235.21 "medication therapy management" means the provision of the following pharmaceutical

338.10 care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's
 338.11 medications:

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

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

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

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

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

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

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

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

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

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

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

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

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

339.13 ~~(4)~~ (3) make use of an electronic patient record system that meets state standards.

235.22 care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's
 235.23 medications:

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

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

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

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

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

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

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

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

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

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

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

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

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

236.23 ~~(4)~~ (3) make use of an electronic patient record system that meets state standards.

339.14 (c) For purposes of reimbursement for medication therapy management services, the
 339.15 commissioner may enroll individual pharmacists as medical assistance providers. The
 339.16 commissioner may also establish ~~contact requirements between the pharmacist and recipient,~~
 339.17 ~~including limiting limits on~~ the number of reimbursable consultations per recipient.

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

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

340.3 **EFFECTIVE DATE.** This section is effective January 1, 2022.

340.4 Sec. 13. Minnesota Statutes 2020, section 256B.0625, subdivision 20, is amended to read:

340.5 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
 340.6 state agency, medical assistance covers case management services to persons with serious
 340.7 and persistent mental illness and children with severe emotional disturbance. Services
 340.8 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
 340.9 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
 340.10 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

340.11 (b) Entities meeting program standards set out in rules governing family community
 340.12 support services as defined in section 245.4871, subdivision 17, are eligible for medical
 340.13 assistance reimbursement for case management services for children with severe emotional
 340.14 disturbance when these services meet the program standards in Minnesota Rules, parts
 340.15 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

340.16 (c) Medical assistance and MinnesotaCare payment for mental health case management
 340.17 shall be made on a monthly basis. In order to receive payment for an eligible child, the
 340.18 provider must document at least a face-to-face contact or a contact by interactive video that

236.24 (c) For purposes of reimbursement for medication therapy management services, the
 236.25 commissioner may enroll individual pharmacists as medical assistance providers. The
 236.26 commissioner may also establish ~~contact requirements between the pharmacist and recipient,~~
 236.27 ~~including limiting limits on~~ the number of reimbursable consultations per recipient.

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

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

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

237.14 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
 237.15 state agency, medical assistance covers case management services to persons with serious
 237.16 and persistent mental illness and children with severe emotional disturbance. Services
 237.17 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
 237.18 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
 237.19 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

237.20 (b) Entities meeting program standards set out in rules governing family community
 237.21 support services as defined in section 245.4871, subdivision 17, are eligible for medical
 237.22 assistance reimbursement for case management services for children with severe emotional
 237.23 disturbance when these services meet the program standards in Minnesota Rules, parts
 237.24 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

237.25 (c) Medical assistance and MinnesotaCare payment for mental health case management
 237.26 shall be made on a monthly basis. In order to receive payment for an eligible child, the
 237.27 provider must document at least a face-to-face contact either in person or by interactive
 237.28 video that meets the requirements of subdivision 20b with the child, the child's parents, or

340.19 meets the requirements of subdivision 20b with the child, the child's parents, or the child's
 340.20 legal representative. To receive payment for an eligible adult, the provider must document:

340.21 (1) at least a face-to-face contact, or a contact by interactive video that meets the
 340.22 requirements of subdivision 20b, with the adult or the adult's legal representative or a contact
 340.23 by interactive video that meets the requirements of subdivision 20b; or

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

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

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

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

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

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

237.29 the child's legal representative. To receive payment for an eligible adult, the provider must
 237.30 document:

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

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

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

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

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

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

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

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

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

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

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

342.5 (2) programming the information systems.

342.6 (l) Payments to counties and tribal agencies for case management expenditures under
 342.7 this section shall only be made from federal earnings from services provided under this
 342.8 section. When this service is paid by the state without a federal share through fee-for-service,
 342.9 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
 342.10 shall include the federal earnings, the state share, and the county share.

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

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

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

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

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

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

342.25 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 342.26 of human services shall notify the revisor of statutes when federal approval is obtained.

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

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

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

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

239.14 (2) programming the information systems.

239.15 (l) Payments to counties and tribal agencies for case management expenditures under
 239.16 this section shall only be made from federal earnings from services provided under this
 239.17 section. When this service is paid by the state without a federal share through fee-for-service,
 239.18 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
 239.19 shall include the federal earnings, the state share, and the county share.

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

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

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

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

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

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

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

342.29 Subd. 20b. ~~Mental health Targeted case management face-to-face contact through~~
342.30 ~~interactive video. (a) Subject to federal approval, contact made for targeted case management~~
342.31 ~~by interactive video shall be eligible for payment if:~~

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

343.2 (i) ~~a hospital;~~

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

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

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

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

343.13 (4) ~~interactive video is used for up to, but not more than, 50 percent of the minimum~~
343.14 ~~required face-to-face contact. (a) Minimum required face-to-face contacts for targeted case~~
343.15 ~~management may be provided through interactive video if interactive video is in the best~~
343.16 ~~interests of the person and is deemed appropriate by the person receiving targeted case~~
343.17 ~~management or the person's legal guardian and the case management provider.~~

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

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

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

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

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

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

240.12 (i) ~~a hospital;~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

344.17 (f) For the purposes of this section, "interactive video" means real-time, two-way
 344.18 interactive audio and visual communications.

344.19 EFFECTIVE DATE. This section is effective upon federal approval. The commissioner
 344.20 of human services shall notify the revisor of statutes when federal approval is obtained.

344.21 Sec. 15. Minnesota Statutes 2020, section 256B.0625, subdivision 46, is amended to read:

344.22 Subd. 46. **Mental health telemedicine telehealth.** ~~Effective January 1, 2006, and Subject~~
 344.23 ~~to federal approval, mental health services that are otherwise covered by medical assistance~~
 344.24 ~~as direct face-to-face services may be provided via two-way interactive video telehealth as~~
 344.25 ~~defined in subdivision 3b. Use of two-way interactive video telehealth to deliver services~~
 344.26 ~~must be medically appropriate to the condition and needs of the person being served.~~
 344.27 ~~Reimbursement is at the same rates and under the same conditions that would otherwise~~

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

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

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

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

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

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

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

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

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

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

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

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

241.29 Subd. 46. **Mental health telemedicine telehealth.** ~~Effective January 1, 2006, and Subject~~
 241.30 ~~to federal approval, mental health services that are otherwise covered by medical assistance~~
 241.31 ~~as direct face-to-face services may be provided via two-way interactive video telehealth as~~
 242.1 ~~defined in subdivision 3b. Use of two-way interactive video telehealth to deliver services~~
 242.2 ~~must be medically appropriate to the condition and needs of the person being served.~~
 242.3 ~~Reimbursement is at the same rates and under the same conditions that would otherwise~~

344.28 apply to the service. ~~The interactive video equipment and connection must comply with~~
 344.29 ~~Medicare standards in effect at the time the service is provided.~~

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

345.1 Sec. 16. Minnesota Statutes 2020, section 256B.0911, subdivision 1a, is amended to read:

345.2 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

345.3 (a) Until additional requirements apply under paragraph (b), "long-term care consultation
 345.4 services" means:

345.5 (1) intake for and access to assistance in identifying services needed to maintain an
 345.6 individual in the most inclusive environment;

345.7 (2) providing recommendations for and referrals to cost-effective community services
 345.8 that are available to the individual;

345.9 (3) development of an individual's person-centered community support plan;

345.10 (4) providing information regarding eligibility for Minnesota health care programs;

345.11 (5) face-to-face long-term care consultation assessments conducted according to
 345.12 subdivision 3a, which may be completed in a hospital, nursing facility, intermediate care
 345.13 facility for persons with developmental disabilities (ICF/DDs), regional treatment centers,
 345.14 or the person's current or planned residence;

345.15 (6) determination of home and community-based waiver and other service eligibility as
 345.16 required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including
 345.17 level of care determination for individuals who need an institutional level of care as
 345.18 determined under subdivision 4e, based on a long-term care consultation assessment and
 345.19 community support plan development, appropriate referrals to obtain necessary diagnostic
 345.20 information, and including an eligibility determination for consumer-directed community
 345.21 supports;

345.22 (7) providing recommendations for institutional placement when there are no
 345.23 cost-effective community services available;

345.24 (8) providing access to assistance to transition people back to community settings after
 345.25 institutional admission;

345.26 (9) providing information about competitive employment, with or without supports, for
 345.27 school-age youth and working-age adults and referrals to the Disability Hub and Disability
 345.28 Benefits 101 to ensure that an informed choice about competitive employment can be made.
 345.29 For the purposes of this subdivision, "competitive employment" means work in the
 345.30 competitive labor market that is performed on a full-time or part-time basis in an integrated
 345.31 setting, and for which an individual is compensated at or above the minimum wage, but not

242.4 apply to the service. ~~The interactive video equipment and connection must comply with~~
 242.5 ~~Medicare standards in effect at the time the service is provided.~~

- 346.1 less than the customary wage and level of benefits paid by the employer for the same or
346.2 similar work performed by individuals without disabilities;
- 346.3 (10) providing information about independent living to ensure that an informed choice
346.4 about independent living can be made; and
- 346.5 (11) providing information about self-directed services and supports, including
346.6 self-directed funding options, to ensure that an informed choice about self-directed options
346.7 can be made.
- 346.8 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c,
346.9 and 3a, "long-term care consultation services" also means:
- 346.10 (1) service eligibility determination for the following state plan services:
- 346.11 (i) personal care assistance services under section 256B.0625, subdivisions 19a and 19c;
- 346.12 (ii) consumer support grants under section 256.476; or
- 346.13 (iii) community first services and supports under section 256B.85;
- 346.14 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
346.15 gaining access to:
- 346.16 (i) relocation targeted case management services available under section 256B.0621,
346.17 subdivision 2, clause (4);
- 346.18 (ii) case management services targeted to vulnerable adults or developmental disabilities
346.19 under section 256B.0924; and
- 346.20 (iii) case management services targeted to people with developmental disabilities under
346.21 Minnesota Rules, part 9525.0016;
- 346.22 (3) determination of eligibility for semi-independent living services under section
346.23 252.275; and
- 346.24 (4) obtaining necessary diagnostic information to determine eligibility under clauses (2)
346.25 and (3).
- 346.26 (c) "Long-term care options counseling" means the services provided by sections 256.01,
346.27 subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and
346.28 follow up once a long-term care consultation assessment has been completed.
- 346.29 (d) "Minnesota health care programs" means the medical assistance program under this
346.30 chapter and the alternative care program under section 256B.0913.
- 347.1 (e) "Lead agencies" means counties administering or tribes and health plans under
347.2 contract with the commissioner to administer long-term care consultation services.
- 347.3 (f) "Person-centered planning" is a process that includes the active participation of a
347.4 person in the planning of the person's services, including in making meaningful and informed

347.5 choices about the person's own goals, talents, and objectives, as well as making meaningful
347.6 and informed choices about the services the person receives, the settings in which the person
347.7 receives the services, and the setting in which the person lives.

347.8 (g) "Informed choice" means a voluntary choice of services, settings, living arrangement,
347.9 and work by a person from all available service and setting options based on accurate and
347.10 complete information concerning all available service and setting options and concerning
347.11 the person's own preferences, abilities, goals, and objectives. In order for a person to make
347.12 an informed choice, all available options must be developed and presented to the person in
347.13 a way the person can understand to empower the person to make fully informed choices.

347.14 (h) "Available service and setting options" or "available options," with respect to the
347.15 home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49,
347.16 means all services and settings defined under the waiver plan for which a waiver applicant
347.17 or waiver participant is eligible.

347.18 (i) "Independent living" means living in a setting that is not controlled by a provider.

347.19 Sec. 17. Minnesota Statutes 2020, section 256B.0911, subdivision 3a, is amended to read:

347.20 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
347.21 planning, or other assistance intended to support community-based living, including persons
347.22 who need assessment in order to determine waiver or alternative care program eligibility,
347.23 must be visited by a long-term care consultation team within 20 calendar days after the date
347.24 on which an assessment was requested or recommended. Upon statewide implementation
347.25 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
347.26 requesting personal care assistance services. The commissioner shall provide at least a
347.27 90-day notice to lead agencies prior to the effective date of this requirement. ~~Face-to-face~~
347.28 Assessments must be conducted according to paragraphs (b) to ~~(j)~~ (q).

347.29 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
347.30 assessors to conduct the assessment. For a person with complex health care needs, a public
347.31 health or registered nurse from the team must be consulted.

347.32 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
347.33 be used to complete a comprehensive, conversation-based, person-centered assessment.
348.1 The assessment must include the health, psychological, functional, environmental, and
348.2 social needs of the individual necessary to develop a person-centered community support
348.3 plan that meets the individual's needs and preferences.

348.4 (d) Except as provided in paragraph (q), the assessment must be conducted by a certified
348.5 assessor in a face-to-face conversational interview with the person being assessed. The
348.6 person's legal representative must provide input during the assessment process and may do
348.7 so remotely if requested. At the request of the person, other individuals may participate in
348.8 the assessment to provide information on the needs, strengths, and preferences of the person
348.9 necessary to develop a community support plan that ensures the person's health and safety.
348.10 Except for legal representatives or family members invited by the person, persons

348.11 participating in the assessment may not be a provider of service or have any financial interest
348.12 in the provision of services. For persons who are to be assessed for elderly waiver customized
348.13 living or adult day services under chapter 256S, with the permission of the person being
348.14 assessed or the person's designated or legal representative, the client's current or proposed
348.15 provider of services may submit a copy of the provider's nursing assessment or written
348.16 report outlining its recommendations regarding the client's care needs. The person conducting
348.17 the assessment must notify the provider of the date by which this information is to be
348.18 submitted. This information shall be provided to the person conducting the assessment prior
348.19 to the assessment. For a person who is to be assessed for waiver services under section
348.20 256B.092 or 256B.49, with the permission of the person being assessed or the person's
348.21 designated legal representative, the person's current provider of services may submit a
348.22 written report outlining recommendations regarding the person's care needs the person
348.23 completed in consultation with someone who is known to the person and has interaction
348.24 with the person on a regular basis. The provider must submit the report at least 60 days
348.25 before the end of the person's current service agreement. The certified assessor must consider
348.26 the content of the submitted report prior to finalizing the person's assessment or reassessment.

348.27 (e) The certified assessor and the individual responsible for developing the coordinated
348.28 service and support plan must complete the community support plan and the coordinated
348.29 service and support plan no more than 60 calendar days from the assessment visit. The
348.30 person or the person's legal representative must be provided with a written community
348.31 support plan within the timelines established by the commissioner, regardless of whether
348.32 the person is eligible for Minnesota health care programs.

348.33 (f) For a person being assessed for elderly waiver services under chapter 256S, a provider
348.34 who submitted information under paragraph (d) shall receive the final written community
348.35 support plan when available and the Residential Services Workbook.

349.1 (g) The written community support plan must include:

349.2 (1) a summary of assessed needs as defined in paragraphs (c) and (d);

349.3 (2) the individual's options and choices to meet identified needs, including:

349.4 (i) all available options for case management services and providers;

349.5 (ii) all available options for employment services, settings, and providers;

349.6 (iii) all available options for living arrangements;

349.7 (iv) all available options for self-directed services and supports, including self-directed

349.8 budget options; and

349.9 (v) service provided in a non-disability-specific setting;

349.10 (3) identification of health and safety risks and how those risks will be addressed,

349.11 including personal risk management strategies;

- 349.12 (4) referral information; and
- 349.13 (5) informal caregiver supports, if applicable.
- 349.14 For a person determined eligible for state plan home care under subdivision 1a, paragraph
349.15 (b), clause (1), the person or person's representative must also receive a copy of the home
349.16 care service plan developed by the certified assessor.
- 349.17 (h) A person may request assistance in identifying community supports without
349.18 participating in a complete assessment. Upon a request for assistance identifying community
349.19 support, the person must be transferred or referred to long-term care options counseling
349.20 services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for
349.21 telephone assistance and follow up.
- 349.22 (i) The person has the right to make the final decision:
- 349.23 (1) between institutional placement and community placement after the recommendations
349.24 have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);
- 349.25 (2) between community placement in a setting controlled by a provider and living
349.26 independently in a setting not controlled by a provider;
- 349.27 (3) between day services and employment services; and
- 349.28 (4) regarding available options for self-directed services and supports, including
349.29 self-directed funding options.
- 350.1 (j) The lead agency must give the person receiving long-term care consultation services
350.2 or the person's legal representative, materials, and forms supplied by the commissioner
350.3 containing the following information:
- 350.4 (1) written recommendations for community-based services and consumer-directed
350.5 options;
- 350.6 (2) documentation that the most cost-effective alternatives available were offered to the
350.7 individual. For purposes of this clause, "cost-effective" means community services and
350.8 living arrangements that cost the same as or less than institutional care. For an individual
350.9 found to meet eligibility criteria for home and community-based service programs under
350.10 chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally
350.11 approved waiver plan for each program;
- 350.12 (3) the need for and purpose of preadmission screening conducted by long-term care
350.13 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
350.14 nursing facility placement. If the individual selects nursing facility placement, the lead
350.15 agency shall forward information needed to complete the level of care determinations and
350.16 screening for developmental disability and mental illness collected during the assessment
350.17 to the long-term care options counselor using forms provided by the commissioner;

350.18 (4) the role of long-term care consultation assessment and support planning in eligibility
350.19 determination for waiver and alternative care programs, and state plan home care, case
350.20 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
350.21 and (b);

350.22 (5) information about Minnesota health care programs;

350.23 (6) the person's freedom to accept or reject the recommendations of the team;

350.24 (7) the person's right to confidentiality under the Minnesota Government Data Practices
350.25 Act, chapter 13;

350.26 (8) the certified assessor's decision regarding the person's need for institutional level of
350.27 care as determined under criteria established in subdivision 4e and the certified assessor's
350.28 decision regarding eligibility for all services and programs as defined in subdivision 1a,
350.29 paragraphs (a), clause (6), and (b);

350.30 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
350.31 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
350.32 (8), and (b), and incorporating the decision regarding the need for institutional level of care
350.33 or the lead agency's final decisions regarding public programs eligibility according to section
351.1 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
351.2 to the person and must visually point out where in the document the right to appeal is stated;
351.3 and

351.4 (10) documentation that available options for employment services, independent living,
351.5 and self-directed services and supports were described to the individual.

351.6 (k) ~~Face-to-face~~ Assessment completed as part of an eligibility determination for multiple
351.7 programs for the alternative care, elderly waiver, developmental disabilities, community
351.8 access for disability inclusion, community alternative care, and brain injury waiver programs
351.9 under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish
351.10 service eligibility for no more than 60 calendar days after the date of assessment.

351.11 (l) The effective eligibility start date for programs in paragraph (k) can never be prior
351.12 to the date of assessment. If an assessment was completed more than 60 days before the
351.13 effective waiver or alternative care program eligibility start date, assessment and support
351.14 plan information must be updated and documented in the department's Medicaid Management
351.15 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
351.16 state plan services, the effective date of eligibility for programs included in paragraph (k)
351.17 cannot be prior to the date the most recent updated assessment is completed.

351.18 (m) If an eligibility update is completed within 90 days of the previous ~~face-to-face~~
351.19 assessment and documented in the department's Medicaid Management Information System
351.20 (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date
351.21 of the previous ~~face-to-face~~ assessment when all other eligibility requirements are met.

351.22 (n) At the time of reassessment, the certified assessor shall assess each person receiving
351.23 waiver residential supports and services currently residing in a community residential setting,
351.24 licensed adult foster care home that is either not the primary residence of the license holder
351.25 or in which the license holder is not the primary caregiver, family adult foster care residence,
351.26 customized living setting, or supervised living facility to determine if that person would
351.27 prefer to be served in a community-living setting as defined in section 256B.49, subdivision
351.28 23, in a setting not controlled by a provider, or to receive integrated community supports
351.29 as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified
351.30 assessor shall offer the person, through a person-centered planning process, the option to
351.31 receive alternative housing and service options.

351.32 (o) At the time of reassessment, the certified assessor shall assess each person receiving
351.33 waiver day services to determine if that person would prefer to receive employment services
351.34 as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified
352.1 assessor shall describe to the person through a person-centered planning process the option
352.2 to receive employment services.

352.3 (p) At the time of reassessment, the certified assessor shall assess each person receiving
352.4 non-self-directed waiver services to determine if that person would prefer an available
352.5 service and setting option that would permit self-directed services and supports. The certified
352.6 assessor shall describe to the person through a person-centered planning process the option
352.7 to receive self-directed services and supports.

352.8 (q) All assessments performed according to this subdivision must be face-to-face unless
352.9 the assessment is a reassessment meeting the requirements of this paragraph. Subject to
352.10 federal approval, remote reassessments conducted by interactive video or telephone may
352.11 substitute for face-to-face reassessments for services provided by alternative care under
352.12 section 256B.0913, the elderly waiver under chapter 256S, the developmental disabilities
352.13 waiver under section 256B.092, and the community access for disability inclusion,
352.14 community alternative care, and brain injury waiver programs under section 256B.49.
352.15 Remote reassessments may be substituted for two consecutive reassessments if followed
352.16 by a face-to-face reassessment. A remote reassessment is permitted only if the person being
352.17 reassessed, the person's legal representative, and the lead agency case manager all agree
352.18 that there is no change in the person's condition, there is no need for a change in service,
352.19 and that a remote reassessment is appropriate. The person being reassessed, or the person's
352.20 legal representative, has the right to refuse a remote reassessment at any time. During a
352.21 remote reassessment, if the certified assessor determines in the assessor's sole judgment
352.22 that a remote reassessment is inappropriate, the certified assessor shall suspend the remote
352.23 reassessment and schedule a face-to-face reassessment to complete the reassessment. All
352.24 other requirements of a face-to-face reassessment apply to a remote reassessment.

352.25 Sec. 18. Minnesota Statutes 2020, section 256B.0911, subdivision 3f, is amended to read:

352.26 Subd. 3f. **Long-term care reassessments and community support plan updates.** (a)
352.27 Prior to a ~~face-to-face~~ reassessment, the certified assessor must review the person's most
352.28 recent assessment. Reassessments must be tailored using the professional judgment of the

352.29 assessor to the person's known needs, strengths, preferences, and circumstances.
352.30 Reassessments provide information to support the person's informed choice and opportunities
352.31 to express choice regarding activities that contribute to quality of life, as well as information
352.32 and opportunity to identify goals related to desired employment, community activities, and
352.33 preferred living environment. Reassessments require a review of the most recent assessment,
352.34 review of the current coordinated service and support plan's effectiveness, monitoring of
353.1 services, and the development of an updated person-centered community support plan.
353.2 Reassessments must verify continued eligibility, offer alternatives as warranted, and provide
353.3 an opportunity for quality assurance of service delivery. ~~Face-to-face~~ Reassessments must
353.4 be conducted annually or as required by federal and state laws and rules. For reassessments,
353.5 the certified assessor and the individual responsible for developing the coordinated service
353.6 and support plan must ensure the continuity of care for the person receiving services and
353.7 complete the updated community support plan and the updated coordinated service and
353.8 support plan no more than 60 days from the reassessment visit.

353.9 (b) The commissioner shall develop mechanisms for providers and case managers to
353.10 share information with the assessor to facilitate a reassessment and support planning process
353.11 tailored to the person's current needs and preferences.

353.12 Sec. 19. Minnesota Statutes 2020, section 256B.0911, subdivision 4d, is amended to read:

353.13 Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the
353.14 policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness
353.15 are served in the most integrated setting appropriate to their needs and have the necessary
353.16 information to make informed choices about home and community-based service options.

353.17 (b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing
353.18 facility must be screened prior to admission according to the requirements outlined in section
353.19 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as
353.20 required under section 256.975, subdivision 7.

353.21 (c) Individuals under 65 years of age who are admitted to nursing facilities with only a
353.22 telephone screening must receive a face-to-face assessment from the long-term care
353.23 consultation team member of the county in which the facility is located or from the recipient's
353.24 county case manager within the timeline established by the commissioner, based on review
353.25 of data.

353.26 (d) At the face-to-face assessment, the long-term care consultation team member or
353.27 county case manager must perform the activities required under subdivision 3b.

353.28 (e) For individuals under 21 years of age, a screening interview which recommends
353.29 nursing facility admission must be face-to-face and approved by the commissioner before
353.30 the individual is admitted to the nursing facility.

353.31 (f) In the event that an individual under 65 years of age is admitted to a nursing facility
353.32 on an emergency basis, the Senior LinkAge Line must be notified of the admission on the

354.1 next working day, and a face-to-face assessment as described in paragraph (c) must be
 354.2 conducted within the timeline established by the commissioner, based on review of data.

354.3 (g) At the face-to-face assessment, the long-term care consultation team member or the
 354.4 case manager must present information about home and community-based options, including
 354.5 consumer-directed options, so the individual can make informed choices. If the individual
 354.6 chooses home and community-based services, the long-term care consultation team member
 354.7 or case manager must complete a written relocation plan within 20 working days of the
 354.8 visit. The plan shall describe the services needed to move out of the facility and a time line
 354.9 for the move which is designed to ensure a smooth transition to the individual's home and
 354.10 community.

354.11 (h) An individual under 65 years of age residing in a nursing facility shall receive a
 354.12 ~~face-to-face assessment~~ reassessment at least every 12 months to review the person's service
 354.13 choices and available alternatives unless the individual indicates, in writing, that annual
 354.14 visits are not desired. In this case, the individual must receive a ~~face-to-face assessment~~
 354.15 reassessment at least once every 36 months for the same purposes. A remote reassessment
 354.16 is permitted only if the person being reassessed, the person's legal representative, and the
 354.17 lead agency case manager all agree that there is no change in the person's condition, there
 354.18 is no need for a change in service, and that a remote reassessment is appropriate. The person
 354.19 being reassessed, or the person's legal representative, has the right to refuse a remote
 354.20 reassessment at any time. During a remote reassessment, if the certified assessor determines
 354.21 in the assessor's sole judgment that a remote reassessment is inappropriate, the certified
 354.22 assessor shall suspend the remote reassessment and schedule a face-to-face reassessment
 354.23 to complete the reassessment. All other requirements of a face-to-face reassessment apply
 354.24 to a remote reassessment.

354.25 (i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county
 354.26 agencies directly for ~~face-to-face~~ assessments for individuals under 65 years of age who
 354.27 are being considered for placement or residing in a nursing facility.

354.28 (j) Funding for preadmission screening follow-up shall be provided to the Disability
 354.29 Hub for the under-60 population by the Department of Human Services to cover options
 354.30 counseling salaries and expenses to provide the services described in subdivisions 7a to 7c.
 354.31 The Disability Hub shall employ, or contract with other agencies to employ, within the
 354.32 limits of available funding, sufficient personnel to provide preadmission screening follow-up
 354.33 services and shall seek to maximize federal funding for the service as provided under section
 354.34 256.01, subdivision 2, paragraph (aa).

355.1 Sec. 20. Minnesota Statutes 2020, section 256B.0924, subdivision 6, is amended to read:

355.2 Subd. 6. **Payment for targeted case management.** (a) Medical assistance and
 355.3 MinnesotaCare payment for targeted case management shall be made on a monthly basis.
 355.4 In order to receive payment for an eligible adult, the provider must document at least one
 355.5 contact per month and not more than two consecutive months without a face-to-face contact
 355.6 or a contact by interactive video that meets the requirements of section 256B.0625,

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

242.7 Subd. 6. **Payment for targeted case management.** (a) Medical assistance and
 242.8 MinnesotaCare payment for targeted case management shall be made on a monthly basis.
 242.9 In order to receive payment for an eligible adult, the provider must document at least one
 242.10 contact per month and not more than two consecutive months without a face-to-face contact
 242.11 either in person or by interactive video that meets the requirements in section 256B.0625,

355.7 subdivision 20b, with the adult or the adult's legal representative, family, primary caregiver,
 355.8 or other relevant persons identified as necessary to the development or implementation of
 355.9 the goals of the personal service plan.

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

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

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

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

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

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

242.12 subdivision 20b with the adult or the adult's legal representative, family, primary caregiver,
 242.13 or other relevant persons identified as necessary to the development or implementation of
 242.14 the goals of the personal service plan.

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

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

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

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

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

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

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

356.13 (i) Notwithstanding section 256B.041, county payments for the cost of case management
 356.14 services provided by county staff shall not be made to the commissioner of management
 356.15 and budget. For the purposes of targeted case management services provided by county
 356.16 staff under this section, the centralized disbursement of payments to counties under section
 356.17 256B.041 consists only of federal earnings from services provided under this section.

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

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

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

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

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

356.27 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 356.28 of human services shall notify the revisor of statutes when federal approval is obtained.

356.29 Sec. 21. Minnesota Statutes 2020, section 256B.094, subdivision 6, is amended to read:

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

357.6 (1) there must be a face-to-face contact, or a contact by interactive video that meets the
 357.7 requirements of section 256B.0625, subdivision 20b, at least once a month except as provided
 357.8 in clause (2); and

357.9 (2) for a client placed outside of the county of financial responsibility, or a client served
 357.10 by tribal social services placed outside the reservation, in an excluded time facility under
 357.11 section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of
 357.12 Children, section 260.93, and the placement in either case is more than 60 miles beyond

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

243.18 (i) Notwithstanding section 256B.041, county payments for the cost of case management
 243.19 services provided by county staff shall not be made to the commissioner of management
 243.20 and budget. For the purposes of targeted case management services provided by county
 243.21 staff under this section, the centralized disbursement of payments to counties under section
 243.22 256B.041 consists only of federal earnings from services provided under this section.

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

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

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

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

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

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

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

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

244.12 (2) for a client placed outside of the county of financial responsibility, or a client served
 244.13 by tribal social services placed outside the reservation, in an excluded time facility under
 244.14 section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of
 244.15 Children, section 260.93, and the placement in either case is more than 60 miles beyond

357.13 the county or reservation boundaries, there must be at least one contact per month and not
357.14 more than two consecutive months without a face-to-face contact.

357.15 Face-to-face contacts under this paragraph may be conducted using interactive video for
357.16 up to two consecutive contacts following each in-person contact.

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

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

357.23 (d) Payment for case management provided by county or tribal social services contracted
357.24 vendors shall be based on a monthly rate negotiated by the host county or tribal social
357.25 services. The negotiated rate must not exceed the rate charged by the vendor for the same
357.26 service to other payers. If the service is provided by a team of contracted vendors, the county
357.27 or tribal social services may negotiate a team rate with a vendor who is a member of the
357.28 team. The team shall determine how to distribute the rate among its members. No
357.29 reimbursement received by contracted vendors shall be returned to the county or tribal social
357.30 services, except to reimburse the county or tribal social services for advance funding provided
357.31 by the county or tribal social services to the vendor.

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

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

244.16 the county or reservation boundaries, there must be at least one contact per month and not
244.17 more than two consecutive months without a face-to-face ~~contact.~~ in-person contact; and

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

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

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

244.26 (d) Payment for case management provided by county or tribal social services contracted
244.27 vendors shall be based on a monthly rate negotiated by the host county or tribal social
244.28 services. The negotiated rate must not exceed the rate charged by the vendor for the same
244.29 service to other payers. If the service is provided by a team of contracted vendors, the county
244.30 or tribal social services may negotiate a team rate with a vendor who is a member of the
244.31 team. The team shall determine how to distribute the rate among its members. No
244.32 reimbursement received by contracted vendors shall be returned to the county or tribal social
244.33 services, except to reimburse the county or tribal social services for advance funding provided
244.34 by the county or tribal social services to the vendor.

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

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

358.14 requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to
 358.15 accomplish this.

358.16 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 358.17 of human services shall notify the revisor of statutes when federal approval is obtained.

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

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

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

245.28 (b) "Clinical supervision" means the overall responsibility of the mental health
 245.29 professional for the control and direction of individualized treatment planning, service
 245.30 delivery, and treatment review for each client. A mental health professional who is an
 245.31 enrolled Minnesota health care program provider accepts full professional responsibility
 245.32 for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work,
 245.33 and oversees or directs the supervisee's work.

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

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

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

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

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

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

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

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

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

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

247.6 (m) "Mental health behavioral aide services" means medically necessary one-on-one
247.7 activities performed by a trained paraprofessional qualified as provided in subdivision 7,
247.8 paragraph (b), clause (3), to assist a child retain or generalize psychosocial skills as previously
247.9 trained by a mental health professional or mental health practitioner and as described in the
247.10 child's individual treatment plan and individual behavior plan. Activities involve working
247.11 directly with the child or child's family as provided in subdivision 9, paragraph (b), clause
247.12 (4).

247.13 (n) "Mental health practitioner" has the meaning given in section 245.462, subdivision
247.14 17, except that a practitioner working in a day treatment setting may qualify as a mental
247.15 health practitioner if the practitioner holds a bachelor's degree in one of the behavioral
247.16 sciences or related fields from an accredited college or university, and: (1) has at least 2,000
247.17 hours of clinically supervised experience in the delivery of mental health services to clients
247.18 with mental illness; (2) is fluent in the language, other than English, of the cultural group
247.19 that makes up at least 50 percent of the practitioner's clients, completes 40 hours of training
247.20 on the delivery of services to clients with mental illness, and receives clinical supervision
247.21 from a mental health professional at least once per week until meeting the required 2,000
247.22 hours of supervised experience; or (3) receives 40 hours of training on the delivery of
247.23 services to clients with mental illness within six months of employment, and clinical

- 247.24 supervision from a mental health professional at least once per week until meeting the
247.25 required 2,000 hours of supervised experience.
- 247.26 (o) "Mental health professional" means an individual as defined in Minnesota Rules,
247.27 part 9505.0370, subpart 18.
- 247.28 (p) "Mental health service plan development" includes:
- 247.29 (1) the development, review, and revision of a child's individual treatment plan, as
247.30 provided in Minnesota Rules, part 9505.0371, subpart 7, including involvement of the client
247.31 or client's parents, primary caregiver, or other person authorized to consent to mental health
247.32 services for the client, and including arrangement of treatment and support activities specified
247.33 in the individual treatment plan; and
- 248.1 (2) administering standardized outcome measurement instruments, determined and
248.2 updated by the commissioner, as periodically needed to evaluate the effectiveness of
248.3 treatment for children receiving clinical services and reporting outcome measures, as required
248.4 by the commissioner.
- 248.5 (q) "Mental illness," for persons at least age 18 but under age 21, has the meaning given
248.6 in section 245.462, subdivision 20, paragraph (a).
- 248.7 (r) "Psychotherapy" means the treatment of mental or emotional disorders or
248.8 maladjustment by psychological means. Psychotherapy may be provided in many modalities
248.9 in accordance with Minnesota Rules, part 9505.0372, subpart 6, including patient and/or
248.10 family psychotherapy; family psychotherapy; psychotherapy for crisis; group psychotherapy;
248.11 or multiple-family psychotherapy. Beginning with the American Medical Association's
248.12 Current Procedural Terminology, standard edition, 2014, the procedure "individual
248.13 psychotherapy" is replaced with "patient and/or family psychotherapy," a substantive change
248.14 that permits the therapist to work with the client's family without the client present to obtain
248.15 information about the client or to explain the client's treatment plan to the family.
248.16 Psychotherapy is appropriate for crisis response when a child has become dysregulated or
248.17 experienced new trauma since the diagnostic assessment was completed and needs
248.18 psychotherapy to address issues not currently included in the child's individual treatment
248.19 plan.
- 248.20 (s) "Rehabilitative services" or "psychiatric rehabilitation services" means a series or
248.21 multidisciplinary combination of psychiatric and psychosocial interventions to: (1) restore
248.22 a child or adolescent to an age-appropriate developmental trajectory that had been disrupted
248.23 by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with,
248.24 counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the
248.25 course of a psychiatric illness. Psychiatric rehabilitation services for children combine
248.26 psychotherapy to address internal psychological, emotional, and intellectual processing
248.27 deficits, and skills training to restore personal and social functioning. Psychiatric
248.28 rehabilitation services establish a progressive series of goals with each achievement building

248.29 upon a prior achievement. Continuing progress toward goals is expected, and rehabilitative
248.30 potential ceases when successive improvement is not observable over a period of time.

248.31 (t) "Skills training" means individual, family, or group training, delivered by or under
248.32 the supervision of a mental health professional, designed to facilitate the acquisition of
248.33 psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate
248.34 developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child
248.35 to self-monitor, compensate for, cope with, counteract, or replace skills deficits or
249.1 maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject
249.2 to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

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

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

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

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

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

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

249.12 (e) An individual treatment plan must:

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

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

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

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

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

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

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

249.30 (7) be completed in consultation with the client's current therapist and key providers and
249.31 provide for ongoing consultation with the client's current therapist to ensure therapeutic
250.1 continuity and to facilitate the client's return to the community. For clients under the age of
250.2 18, the treatment team must consult with parents and guardians in developing the treatment
250.3 plan;

250.4 (8) if a need for substance use disorder treatment is indicated by validated assessment:
250.5 (i) identify goals, objectives, and strategies of substance use disorder treatment; develop
250.6 a schedule for accomplishing treatment goals and objectives; and identify the individuals
250.7 responsible for providing treatment services and supports;

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

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

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

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

250.21 (g) For a client age 18 or older, the treatment team may disclose to a family member,
250.22 other relative, or a close personal friend of the client, or other person identified by the client,
250.23 the protected health information directly relevant to such person's involvement with the
250.24 client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the
250.25 client is present, the treatment team shall obtain the client's agreement, provide the client
250.26 with an opportunity to object, or reasonably infer from the circumstances, based on the
250.27 exercise of professional judgment, that the client does not object. If the client is not present
250.28 or is unable, by incapacity or emergency circumstances, to agree or object, the treatment
250.29 team may, in the exercise of professional judgment, determine whether the disclosure is in
250.30 the best interests of the client and, if so, disclose only the protected health information that
250.31 is directly relevant to the family member's, relative's, friend's, or client-identified person's
250.32 involvement with the client's health care. The client may orally agree or object to the
250.33 disclosure and may prohibit or restrict disclosure to specific individuals.

- 251.1 (h) The treatment team shall provide interventions to promote positive interpersonal
251.2 relationships.
- 251.3 (i) The services and responsibilities of the psychiatric provider may be provided through
251.4 telehealth as defined under section 256B.0625, subdivision 3b, when necessary to prevent
251.5 disruption in client services or to maintain the required psychiatric staffing level.
- 251.6 Sec. 21. Minnesota Statutes 2020, section 256B.0949, subdivision 13, is amended to read:
- 251.7 Subd. 13. **Covered services.** (a) The services described in paragraphs (b) to (l) are
251.8 eligible for reimbursement by medical assistance under this section. Services must be
251.9 provided by a qualified EIDBI provider and supervised by a QSP. An EIDBI service must
251.10 address the person's medically necessary treatment goals and must be targeted to develop,
251.11 enhance, or maintain the individual developmental skills of a person with ASD or a related
251.12 condition to improve functional communication, including nonverbal or social
251.13 communication, social or interpersonal interaction, restrictive or repetitive behaviors,
251.14 hyperreactivity or hyporeactivity to sensory input, behavioral challenges and self-regulation,
251.15 cognition, learning and play, self-care, and safety.
- 251.16 (b) EIDBI treatment must be delivered consistent with the standards of an approved
251.17 modality, as published by the commissioner. EIDBI modalities include:
- 251.18 (1) applied behavior analysis (ABA);
- 251.19 (2) developmental individual-difference relationship-based model (DIR/Floortime);
- 251.20 (3) early start Denver model (ESDM);
- 251.21 (4) PLAY project;
- 251.22 (5) relationship development intervention (RDI); or
- 251.23 (6) additional modalities not listed in clauses (1) to (5) upon approval by the
251.24 commissioner.
- 251.25 (c) An EIDBI provider may use one or more of the EIDBI modalities in paragraph (b),
251.26 clauses (1) to (5), as the primary modality for treatment as a covered service, or several
251.27 EIDBI modalities in combination as the primary modality of treatment, as approved by the
251.28 commissioner. An EIDBI provider that identifies and provides assurance of qualifications
251.29 for a single specific treatment modality must document the required qualifications to meet
251.30 fidelity to the specific model.
- 251.31 (d) Each qualified EIDBI provider must identify and provide assurance of qualifications
251.32 for professional licensure certification, or training in evidence-based treatment methods,
252.1 and must document the required qualifications outlined in subdivision 15 in a manner
252.2 determined by the commissioner.

- 252.3 (e) CMDE is a comprehensive evaluation of the person's developmental status to
 252.4 determine medical necessity for EIDBI services and meets the requirements of subdivision
 252.5 5. The services must be provided by a qualified CMDE provider.
- 252.6 (f) EIDBI intervention observation and direction is the clinical direction and oversight
 252.7 of EIDBI services by the QSP, level I treatment provider, or level II treatment provider,
 252.8 including developmental and behavioral techniques, progress measurement, data collection,
 252.9 function of behaviors, and generalization of acquired skills for the direct benefit of a person.
 252.10 EIDBI intervention observation and direction informs any modification of the current
 252.11 treatment protocol to support the outcomes outlined in the ITP.
- 252.12 (g) Intervention is medically necessary direct treatment provided to a person with ASD
 252.13 or a related condition as outlined in their ITP. All intervention services must be provided
 252.14 under the direction of a QSP. Intervention may take place across multiple settings. The
 252.15 frequency and intensity of intervention services are provided based on the number of
 252.16 treatment goals, person and family or caregiver preferences, and other factors. Intervention
 252.17 services may be provided individually or in a group. Intervention with a higher provider
 252.18 ratio may occur when deemed medically necessary through the person's ITP.
- 252.19 (1) Individual intervention is treatment by protocol administered by a single qualified
 252.20 EIDBI provider delivered ~~face-to-face~~ to one person.
- 252.21 (2) Group intervention is treatment by protocol provided by one or more qualified EIDBI
 252.22 providers, delivered to at least two people who receive EIDBI services.
- 252.23 (h) ITP development and ITP progress monitoring is development of the initial, annual,
 252.24 and progress monitoring of an ITP. ITP development and ITP progress monitoring documents
 252.25 provide oversight and ongoing evaluation of a person's treatment and progress on targeted
 252.26 goals and objectives and integrate and coordinate the person's and the person's legal
 252.27 representative's information from the CMDE and ITP progress monitoring. This service
 252.28 must be reviewed and completed by the QSP, and may include input from a level I provider
 252.29 or a level II provider.
- 252.30 (i) Family caregiver training and counseling is specialized training and education for a
 252.31 family or primary caregiver to understand the person's developmental status and help with
 252.32 the person's needs and development. This service must be provided by the QSP, level I
 252.33 provider, or level II provider.
- 253.1 (j) A coordinated care conference is a voluntary ~~face-to-face~~ meeting with the person
 253.2 and the person's family to review the CMDE or ITP progress monitoring and to integrate
 253.3 and coordinate services across providers and service-delivery systems to develop the ITP.
 253.4 This service must be provided by the QSP and may include the CMDE provider or a level
 253.5 I provider or a level II provider.
- 253.6 (k) Travel time is allowable billing for traveling to and from the person's home, school,
 253.7 a community setting, or place of service outside of an EIDBI center, clinic, or office from
 253.8 a specified location to provide ~~face-to-face~~ in-person EIDBI intervention, observation and

358.18 Sec. 22. Minnesota Statutes 2020, section 256B.49, subdivision 14, is amended to read:

358.19 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be
358.20 conducted by certified assessors according to section 256B.0911, subdivision 2b.

358.21 (b) There must be a determination that the client requires a hospital level of care or a
358.22 nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and
358.23 subsequent assessments to initiate and maintain participation in the waiver program.

358.24 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
358.25 appropriate to determine nursing facility level of care for purposes of medical assistance
358.26 payment for nursing facility services, only ~~face-to-face~~ assessments conducted according
358.27 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
358.28 determination or a nursing facility level of care determination must be accepted for purposes
358.29 of initial and ongoing access to waiver services payment.

358.30 (d) Recipients who are found eligible for home and community-based services under
358.31 this section before their 65th birthday may remain eligible for these services after their 65th
358.32 birthday if they continue to meet all other eligibility factors.

359.1 Sec. 23. Minnesota Statutes 2020, section 256J.09, subdivision 3, is amended to read:

359.2 Subd. 3. **Submitting application form.** (a) A county agency must offer, in person or
359.3 by mail, the application forms prescribed by the commissioner as soon as a person makes
359.4 a written or oral inquiry. At that time, the county agency must:

359.5 (1) inform the person that assistance begins with on the date that the signed application
359.6 is received by the county agency either as a written application; an application submitted
359.7 by telephone; or an application submitted through Internet telepresence; or on the date that
359.8 all eligibility criteria are met, whichever is later;

253.9 direction, or family caregiver training and counseling. The person's ITP must specify the
253.10 reasons the provider must travel to the person.

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

266.1 Sec. 11. Minnesota Statutes 2020, section 256J.08, subdivision 21, is amended to read:

266.2 Subd. 21. **Date of application.** "Date of application" means the date on which the county
266.3 agency receives an applicant's signed application as a signed written application, an
266.4 application submitted by telephone, or an application submitted through Internet telepresence.

266.5 Sec. 12. Minnesota Statutes 2020, section 256J.09, subdivision 3, is amended to read:

266.6 Subd. 3. **Submitting application form.** (a) A county agency must offer, in person or
266.7 by mail, the application forms prescribed by the commissioner as soon as a person makes
266.8 a written or oral inquiry. At that time, the county agency must:

266.9 (1) inform the person that assistance begins with on the date that the signed application
266.10 is received by the county agency either as a signed written application; an application
266.11 submitted by telephone; or an application submitted through Internet telepresence; or on
266.12 the date that all eligibility criteria are met, whichever is later;

359.9 (2) inform a person that the person may submit the application by telephone or through
359.10 Internet telepresence;

359.11 (3) inform a person that when the person submits the application by telephone or through
359.12 Internet telepresence, the county agency must receive a signed written application within
359.13 30 days of the date that the person submitted the application by telephone or through Internet
359.14 telepresence;

359.15 (4) inform the person that any delay in submitting the application will reduce the amount
359.16 of assistance paid for the month of application;

359.17 ~~(3)~~ (5) inform a person that the person may submit the application before an interview;

359.18 ~~(4)~~ (6) explain the information that will be verified during the application process by
359.19 the county agency as provided in section 256J.32;

359.20 ~~(5)~~ (7) inform a person about the county agency's average application processing time
359.21 and explain how the application will be processed under subdivision 5;

359.22 ~~(6)~~ (8) explain how to contact the county agency if a person's application information
359.23 changes and how to withdraw the application;

359.24 ~~(7)~~ (9) inform a person that the next step in the application process is an interview and
359.25 what a person must do if the application is approved including, but not limited to, attending
359.26 orientation under section 256J.45 and complying with employment and training services
359.27 requirements in sections 256J.515 to 256J.57;

359.28 ~~(8)~~ (10) inform the person that ~~the an~~ interview must be conducted. The interview may
359.29 be conducted face-to-face in the county office or at a location mutually agreed upon, through
359.30 Internet telepresence, or at a location mutually agreed upon by telephone;

359.31 ~~(9) inform a person who has received MFIP or DWP in the past 12 months of the option~~
359.32 ~~to have a face-to-face, Internet telepresence, or telephone interview;~~

360.1 ~~(10)~~ (11) explain the child care and transportation services that are available under
360.2 paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

360.3 ~~(11)~~ (12) identify any language barriers and arrange for translation assistance during
360.4 appointments, including, but not limited to, screening under subdivision 3a, orientation
360.5 under section 256J.45, and assessment under section 256J.521.

360.6 (b) Upon receipt of a signed application, the county agency must stamp the date of receipt
360.7 on the face of the application. The county agency must process the application within the
360.8 time period required under subdivision 5. An applicant may withdraw the application at
360.9 any time by giving written or oral notice to the county agency. The county agency must
360.10 issue a written notice confirming the withdrawal. The notice must inform the applicant of
360.11 the county agency's understanding that the applicant has withdrawn the application and no
360.12 longer wants to pursue it. When, within ten days of the date of the agency's notice, an

266.13 (2) inform a person that the person may submit the application by telephone or through
266.14 Internet telepresence;

266.15 (3) inform a person that when the person submits the application by telephone or through
266.16 Internet telepresence, the county agency must receive a signed written application within
266.17 30 days of the date that the person submitted the application by telephone or through Internet
266.18 telepresence;

266.19 ~~(2)~~ (4) inform the person that any delay in submitting the application will reduce the
266.20 amount of assistance paid for the month of application;

266.21 ~~(3)~~ (5) inform a person that the person may submit the application before an interview;

266.22 ~~(4)~~ (6) explain the information that will be verified during the application process by
266.23 the county agency as provided in section 256J.32;

266.24 ~~(5)~~ (7) inform a person about the county agency's average application processing time
266.25 and explain how the application will be processed under subdivision 5;

266.26 ~~(6)~~ (8) explain how to contact the county agency if a person's application information
266.27 changes and how to withdraw the application;

266.28 ~~(7)~~ (9) inform a person that the next step in the application process is an interview and
266.29 what a person must do if the application is approved including, but not limited to, attending
266.30 orientation under section 256J.45 and complying with employment and training services
266.31 requirements in sections 256J.515 to 256J.57;

267.1 ~~(8)~~ (10) inform the person that ~~the an~~ interview must be conducted. The interview may
267.2 be conducted face-to-face in the county office or at a location mutually agreed upon, through
267.3 Internet telepresence, or at a location mutually agreed upon by telephone;

267.4 ~~(9) inform a person who has received MFIP or DWP in the past 12 months of the option~~
267.5 ~~to have a face-to-face, Internet telepresence, or telephone interview;~~

267.6 ~~(10)~~ (11) explain the child care and transportation services that are available under
267.7 paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

267.8 ~~(11)~~ (12) identify any language barriers and arrange for translation assistance during
267.9 appointments, including, but not limited to, screening under subdivision 3a, orientation
267.10 under section 256J.45, and assessment under section 256J.521.

267.11 (b) Upon receipt of a signed application, the county agency must stamp the date of receipt
267.12 on the face of the application. The county agency must process the application within the
267.13 time period required under subdivision 5. An applicant may withdraw the application at
267.14 any time by giving written or oral notice to the county agency. The county agency must
267.15 issue a written notice confirming the withdrawal. The notice must inform the applicant of
267.16 the county agency's understanding that the applicant has withdrawn the application and no
267.17 longer wants to pursue it. When, within ten days of the date of the agency's notice, an

360.13 applicant informs a county agency, in writing, that the applicant does not wish to withdraw
 360.14 the application, the county agency must reinstate the application and finish processing the
 360.15 application.

360.16 (c) Upon a participant's request, the county agency must arrange for transportation and
 360.17 child care or reimburse the participant for transportation and child care expenses necessary
 360.18 to enable participants to attend the screening under subdivision 3a and orientation under
 360.19 section 256J.45.

360.20 Sec. 24. Minnesota Statutes 2020, section 256J.45, subdivision 1, is amended to read:

360.21 Subdivision 1. **County agency to provide orientation.** A county agency must provide
 360.22 ~~a face-to-face~~ an orientation to each MFIP caregiver unless the caregiver is:

360.23 (1) a single parent, or one parent in a two-parent family, employed at least 35 hours per
 360.24 week; or

360.25 (2) a second parent in a two-parent family who is employed for 20 or more hours per
 360.26 week provided the first parent is employed at least 35 hours per week.

360.27 The county agency must inform caregivers who are not exempt under clause (1) or (2) that
 360.28 failure to attend the orientation is considered an occurrence of noncompliance with program
 360.29 requirements, and will result in the imposition of a sanction under section 256J.46. If the
 360.30 client complies with the orientation requirement prior to the first day of the month in which
 360.31 the grant reduction is proposed to occur, the orientation sanction shall be lifted.

267.18 applicant informs a county agency, in writing, that the applicant does not wish to withdraw
 267.19 the application, the county agency must reinstate the application and finish processing the
 267.20 application.

267.21 (c) Upon a participant's request, the county agency must arrange for transportation and
 267.22 child care or reimburse the participant for transportation and child care expenses necessary
 267.23 to enable participants to attend the screening under subdivision 3a and orientation under
 267.24 section 256J.45.

269.14 Sec. 15. Minnesota Statutes 2020, section 256J.45, subdivision 1, is amended to read:

269.15 Subdivision 1. **County agency to provide orientation.** A county agency must provide
 269.16 ~~a face-to-face~~ an orientation to each MFIP caregiver unless the caregiver is:

269.17 (1) a single parent, or one parent in a two-parent family, employed at least 35 hours per
 269.18 week; or

269.19 (2) a second parent in a two-parent family who is employed for 20 or more hours per
 269.20 week provided the first parent is employed at least 35 hours per week.

269.21 The county agency must inform caregivers who are not exempt under clause (1) or (2) that
 269.22 failure to attend the orientation is considered an occurrence of noncompliance with program
 269.23 requirements, and will result in the imposition of a sanction under section 256J.46. If the
 269.24 client complies with the orientation requirement prior to the first day of the month in which
 269.25 the grant reduction is proposed to occur, the orientation sanction shall be lifted.

270.7 Sec. 17. Minnesota Statutes 2020, section 256J.95, subdivision 5, is amended to read:

270.8 Subd. 5. **Submitting application form.** The eligibility date for the diversionary work
 270.9 program begins with on the date that the signed combined application form (CAF) is received
 270.10 by the county agency either as a signed written application; an application submitted by
 270.11 telephone; or an application submitted through Internet telepresence; or on the date that
 270.12 diversionary work program eligibility criteria are met, whichever is later. The county agency
 270.13 must inform an applicant that when the applicant submits the application by telephone or
 270.14 through Internet telepresence, the county agency must receive a signed written application
 270.15 within 30 days of the date that the applicant submitted the application by telephone or
 270.16 through Internet telepresence. The county agency must inform the applicant that any delay
 270.17 in submitting the application will reduce the benefits paid for the month of application. The
 270.18 county agency must inform a person that an application may be submitted before the person
 270.19 has an interview appointment. Upon receipt of a signed application, the county agency must
 270.20 stamp the date of receipt on the face of the application. The applicant may withdraw the
 270.21 application at any time prior to approval by giving written or oral notice to the county
 270.22 agency. The county agency must follow the notice requirements in section 256J.09,
 270.23 subdivision 3, when issuing a notice confirming the withdrawal.

361.1 Sec. 25. Minnesota Statutes 2020, section 256S.05, subdivision 2, is amended to read:

361.2 Subd. 2. **Nursing facility level of care determination required.** Notwithstanding other
 361.3 assessments identified in section 144.0724, subdivision 4, only face-to-face assessments
 361.4 conducted according to section 256B.0911, subdivisions 3, 3a, and 3b, that result in a nursing
 361.5 facility level of care determination at initial and subsequent assessments shall be accepted
 361.6 for purposes of a participant's initial and ongoing participation in the elderly waiver and a
 361.7 service provider's access to service payments under this chapter.

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

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

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

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

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

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

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

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

254.4 The commissioner of human services, in consultation with enrollees, providers, and
 254.5 other interested stakeholders, shall study the viability of the use of audio-only communication
 254.6 as a permitted option for delivering services through telehealth within the public health care
 254.7 programs. The study shall examine the use of audio-only communication in supporting
 254.8 equitable access to health care services, including behavioral health services for the elderly,
 254.9 rural communities, and communities of color, and eliminating barriers for vulnerable and
 254.10 underserved populations. The commissioner shall submit recommendations to the chairs

361.8 Sec. 26. STUDY OF TELEHEALTH.

361.9 (a) The commissioner of health, in consultation with the commissioners of human services
 361.10 and commerce, shall study the impact of telehealth payment methodologies and expansion
 361.11 under the Minnesota Telehealth Act on the coverage and provision of health care services
 361.12 under public health care programs and private health insurance. The study shall review and
 361.13 make recommendations related to:

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

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

361.19 (3) the use of audio-only communication in supporting equitable access to health care
 361.20 services, including behavioral health services for the elderly, rural communities, and
 361.21 communities of color, and eliminating barriers for vulnerable and underserved populations;

361.22 (4) whether there is evidence to suggest that increased access to telehealth improves
 361.23 health outcomes and, if so, for which services and populations; and

361.24 (5) the effect of payment parity on public and private health care costs, health care
 361.25 premiums, and health outcomes.

361.26 (b) When conducting the study, the commissioner shall consult with stakeholders and
 361.27 communities impacted by telehealth payment and expansion. The commissioner,

254.11 and ranking minority members of the legislative committees with jurisdiction over health
 254.12 and human services policy and finances, by December 15, 2022.

254.13 Sec. 24. STUDY OF TELEHEALTH.

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

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

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

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

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

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

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

255.1 (b) In conducting the study, the commissioner shall consult with stakeholders and
 255.2 communities impacted by telehealth payment and expansion. The commissioner,

361.28 notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, may use data available
 361.29 under that section to conduct the study. The commissioner shall report findings to the chairs
 361.30 and ranking minority members of the legislative committees with jurisdiction over health
 361.31 care policy and finance and commerce, by February 15, 2023.

362.1 **Sec. 27. EXPIRATION DATE.**

362.2 **(a) Sections 1 to 15, 20, and 21 expire July 1, 2023.**

362.3 **(b) Notwithstanding paragraph (a), the definition of "originating site" in Minnesota**

362.4 **Statutes, section 256B.0625, subdivision 3b, paragraph (d), clause (3), shall not expire.**

255.3 notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, may use data available
 255.4 under that section to conduct the study. The commissioner shall report findings to the chairs
 255.5 and ranking minority members of the legislative committees with jurisdiction over health
 255.6 and human services policy and finance and commerce, by February 15, 2024.

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

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

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

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

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

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

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

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

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

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

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

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

- 256.1 (11) one member from a rural nonprofit foundation with expertise in delivering health
256.2 and human services via broadband, appointed by the Blandin Foundation;
- 256.3 (12) one member representing child advocacy centers, appointed by the Minnesota Social
256.4 Service Association;
- 256.5 (13) one member appointed by the Minnesota Social Service Association;
- 256.6 (14) one member appointed by the Medical Alley Association;
- 256.7 (15) one member appointed by the Minnesota Nurses Association;
- 256.8 (16) one member appointed by the chief justice of the supreme court; and
- 256.9 (17) the state public defender or a designee.
- 256.10 (b) In addition to the members identified in paragraph (a), the task force shall include
256.11 the following members as ex officio, nonvoting members:
- 256.12 (1) the commissioner of corrections or a designee;
- 256.13 (2) the commissioner of human services or a designee;
- 256.14 (3) the commissioner of health or a designee; and
- 256.15 (4) the commissioner of education or a designee.
- 256.16 Subd. 2. **Appointment deadline; first meeting; chair.** Appointing authorities must
256.17 complete appointments by June 15, 2021. The task force shall select a chair from among
256.18 their members at their first meeting. The member appointed by the senate majority leader
256.19 shall convene the first meeting of the task force by July 15, 2021.
- 256.20 Subd. 3. **Duties.** The task force shall:
- 256.21 (1) explore opportunities for improving behavioral health and other health care service
256.22 delivery through the use of a common interoperable person-centered telepresence platform
256.23 that provides HIPAA compliant connectivity and technical support to potential users;
- 256.24 (2) review and coordinate state and local innovation initiatives and investments designed
256.25 to leverage telepresence connectivity and collaboration for Minnesotans;
- 256.26 (3) determine standards for a single interoperable telepresence platform;
- 256.27 (4) determine statewide capabilities for a single interoperable telepresence platform;
- 256.28 (5) identify barriers to providing a telepresence technology, including limited availability
256.29 of bandwidth, limitations in providing certain services via telepresence, and broadband
256.30 infrastructure needs;

- 257.1 (6) identify and make recommendations for governance that will assure person-centered
 257.2 responsiveness;
- 257.3 (7) identify how the business model can be innovated to provide an incentive for ongoing
 257.4 innovation in Minnesota's health care, human services, education, corrections, and related
 257.5 ecosystems;
- 257.6 (8) identify criteria for suggested deliverables including:
- 257.7 (i) equitable statewide access;
- 257.8 (ii) evaluating bandwidth availability; and
- 257.9 (iii) competitive pricing;
- 257.10 (9) identify sustainable financial support for a single telepresence platform, including
 257.11 infrastructure costs and startup costs for potential users;
- 257.12 (10) identify the benefits to partners in the private sector, state, political subdivisions,
 257.13 tribal governments, and the constituents they serve in using a common person-centered
 257.14 telepresence platform for delivering behavioral health services; and
- 257.15 (11) consult with members of communities who are likely to use a common
 257.16 person-centered telepresence platform, including communities of color, the disability
 257.17 community, and other underserved communities.
- 257.18 Subd. 4. **Administrative support.** The Legislative Coordinating Commission shall
 257.19 provide administrative support to the task force. The Legislative Coordinating Commission
 257.20 may provide meeting space or may use space provided by the Minnesota Social Service
 257.21 Association for meetings.
- 257.22 Subd. 5. **Per diem; expenses.** Public members of the task force may be compensated
 257.23 and have their expenses reimbursed as provided in Minnesota Statutes, section 15.059,
 257.24 subdivision 3.
- 257.25 Subd. 6. **Report.** The task force shall report to the chairs and ranking minority members
 257.26 of the committees in the senate and the house of representatives with primary jurisdiction
 257.27 over health and state information technology by January 15, 2022, with recommendations
 257.28 related to expanding the state's telepresence platform and any legislation required to
 257.29 implement the recommendations.
- 257.30 Subd. 7. **Expiration.** The task force expires July 31, 2022, or the day after the task force
 257.31 submits the report required in this section, whichever is earlier.
- 258.1 Sec. 26. **REVISOR INSTRUCTION.**
- 258.2 In Minnesota Statutes and Minnesota Rules, the revisor of statutes shall substitute the
 258.3 term "telemedicine" with "telehealth" whenever the term appears and substitute Minnesota

362.5 Sec. 28. **REVISOR INSTRUCTION.**

362.6 The revisor of statutes shall substitute the term "telemedicine" with "telehealth" whenever
 362.7 the term appears in Minnesota Statutes and substitute Minnesota Statutes, section 62A.673,

362.8 whenever references to Minnesota Statutes, sections 62A.67, 62A.671, and 62A.672, appear
362.9 in Minnesota Statutes.

362.10 Sec. 29. **REPEALER.**

362.11 (a) Minnesota Statutes 2020, sections 62A.67; 62A.671; and 62A.672, are repealed
362.12 January 1, 2022, and are revived and reenacted July 1, 2023.

362.13 (b) Minnesota Statutes 2020, sections 256B.0596; and 256B.0924, subdivision 4a, are
362.14 repealed upon federal approval and are revived and reenacted July 1, 2023. The commissioner
362.15 of human services shall notify the revisor of statutes when federal approval is obtained.

258.4 Statutes, section 62A.673, whenever references to Minnesota Statutes, sections 62A.67,
258.5 62A.671, and 62A.672 appear.

258.6 Sec. 27. **REPEALER.**

258.7 Minnesota Statutes 2020; 256.0596; and section 256B.0924, subdivision 4a, sections
258.8 62A.67; 62A.671; 62A.672, are repealed.