

The full text omnibus bill can be found here: [HF 33 2nd Engrossment - 92nd Legislature, 2021 1st Special Session \(2021 - 2021\)](#)

Pieces of text that are underlined and in red are new additions to Minnesota legislation. Text that has been ~~struck through~~ was removed from legislation.

High level summary of significant changes to telehealth legislation:

- Medical Assistance—telehealth services are covered “in the same manner” as in person services. Services are paid at their full allowable rate.
 - Telehealth is covered for FQHCs, Rural Health Clinics, Indian Health Services, and CCBHCs and meet the face-to-face requirement.
 - Treatment plans can be signed through verbal approval or electronic means.
 - Coverage for telehealth is expanded to include the services of peer and family specialists, mental health rehabilitation workers, behavioral health aides, treatment coordinators, alcohol and drug counselors, and recovery peer specialists.
 - Mental health case management is covered for interactive video services. Targeted case management services can also be provided by interactive video, if it is in the best interest of the client.
 - Telehealth for video school linked mental health services and intermediate school districts is continued until 2023.
 - A study of impact of telehealth services is required including an assessment of payment parity and the impact of audio-only services.
 - Audio only services are covered for Medical Assistance until July 1, 2023.
 - Originating site is defined as "a site at which a patient is located at the time health care services are provided to the patient by means of telehealth."
 - Distant site is defined as “a site at which a health care provider is located while providing health care services or consultations by means of telehealth.”
- Minnesota based health plans (does not include self-insured or ERISA plans which follow federal regulation)
 - A health plan sold, issued, or renewed by a health carrier (insurer) in Minnesota must cover services in the same manner as in person services.
 - Coverage cannot be limited based on geography
 - Coverage must be based on the same provider network as for in person services
 - Carriers may not deny coverage for services solely because they are provided through telehealth
 - A carrier must reimburse for telehealth at the same rate as in person services
 - Audio only services, when appropriate, must be covered at the same rate as in person services. Audio services must be based on a scheduled appointment, except for substance use disorder services which may be provided without an appointment in emergency situations. This coverage of audio-only services expires July 1, 2023.

ARTICLE 6: TELEHEALTH

<i>Text of the legislation</i>	<i>Summary of changes to telehealth</i>
<p>Section 1. [62A.673] COVERAGE OF SERVICES PROVIDED THROUGH TELEHEALTH.</p> <p><u>Subdivision 1.</u> Citation. <u>This section may be cited as the "Minnesota Telehealth Act."</u></p> <p><u>Subd. 2. Definitions.</u> (a) <u>For purposes of this section, the terms defined in this subdivision have the meanings given.</u> (b) <u>"Distant site" means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.</u> (c) <u>"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</u></p>	<p>Section 1: Section 1 [62A.673] is a complete replacement of the previous Minnesota Telehealth Act (62A.67, 62A.671, and 62A.672). The section establishes requirements for the coverage of services delivered through telehealth for private sector health plans. Changes include expanding the provider types that can provide telehealth, providing coverage for audio-only communication until</p>

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 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 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. Until July 1, 2023, telehealth also includes audio-only communication between a health care provider and a patient in accordance with subdivision 6, paragraph (b). Telehealth does not include communication between health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an e-mail or facsimile transmission. Telehealth does not include telemonitoring services as defined in paragraph (i).

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

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

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

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

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

(e) Nothing in this section:

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

(2) prohibits a health carrier from:

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

July 1, 2023, expanding parity requirements, setting requirements related to telehealth equipment, and requiring coverage of telemonitoring services

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

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

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

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

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

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

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

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

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

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

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

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

(d) Nothing in this subdivision prohibits a health carrier and health care provider from entering into a contract that includes a value-based reimbursement arrangement for the delivery of covered services that may include services delivered through telehealth, and such an arrangement shall not be considered a violation of this subdivision.

Subd. 6. Telehealth equipment. (a) A health carrier must not require a health care provider to use specific telecommunications technology and equipment as a condition of coverage under this section, provided the health care provider uses telecommunications technology and equipment that complies with current industry interoperable standards and complies with standards required under the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and regulations promulgated under that Act, unless authorized under this section.

(b) A health carrier must provide coverage for health care services delivered through telehealth by means of the use of audio-only communication if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication. Substance use disorder treatment services and mental health care services delivered through telehealth by means of audio-only communication may be covered without a scheduled appointment if the communication was initiated by the enrollee while in an emergency or crisis situation and a scheduled appointment was not possible due to the need of an immediate response. This paragraph expires July 1, 2023.

<p>Subd. 7. <u>Telemonitoring services.</u> <u>A health carrier must provide coverage for telemonitoring services if:</u></p> <p>(1) <u>the telemonitoring service is medically appropriate based on the enrollee's medical condition or status;</u></p> <p>(2) <u>the enrollee is cognitively and physically capable of operating the monitoring device or equipment, or the enrollee has a caregiver who is willing and able to assist with the monitoring device or equipment; and</u></p> <p>(3) <u>the enrollee resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.</u></p> <p>Subd. 8. <u>Exception.</u> <u>This section does not apply to coverage provided to state public health care program enrollees under chapter 256B or 256L.</u></p>	
<p>Sec. 2. Minnesota Statutes 2020, section 147.033, is amended to read: 147.033 PRACTICE OF TELEMEDICINE <u>TELEHEALTH.</u></p> <p>Subdivision 1. Definition. For the purposes of this section, "telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way interactive audio, and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, that facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. "<u>telehealth</u>" has the meaning given in section 62A.673, subdivision 2, paragraph (h).</p> <p>Subd. 2. Physician-patient relationship. A physician-patient relationship may be established through telemedicine <u>telehealth</u>.</p> <p>Subd. 3. Standards of practice and conduct. A physician providing health care services by telemedicine <u>telehealth</u> in this state shall be held to the same standards of practice and conduct as provided in this chapter for in-person health care services.</p>	<p>Section 2: Updates the definition of telehealth (formerly "telemedicine") and makes conforming changes to the telehealth section in the physician licensure statute</p>
<p>Sec. 3. Minnesota Statutes 2020, section 151.37, subdivision 2, is amended to read:</p> <p>Subd. 2. Prescribing and filing. (a) A licensed practitioner in the course of professional practice only, may prescribe, administer, and dispense a legend drug, and may cause the same to be administered by a nurse, a physician assistant, or medical student or resident under the practitioner's direction and supervision, and may cause a person who is an appropriately certified, registered, or licensed health care professional to prescribe, dispense, and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference to a specific patient, by directing a licensed dietitian or licensed nutritionist, pursuant to section 148.634; a nurse, pursuant to section 148.235, subdivisions 8 and 9; physician assistant; medical student or resident; or pharmacist according to section 151.01, subdivision 27, to adhere to a particular practice guideline or protocol when treating patients whose condition falls within such guideline or protocol, and when such guideline or protocol specifies the circumstances under which the legend drug is to be prescribed and administered. An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug. This paragraph applies to a physician assistant only if the physician assistant meets the requirements of section 147A.18 <u>sections 147A.02 and 147A.09.</u></p> <p>(b) The commissioner of health, if a licensed practitioner, or a person designated by the commissioner who is a licensed practitioner, may prescribe a legend drug to an individual or by protocol for mass dispensing purposes where the commissioner finds that the</p>	<p>Section 3: Permits the required examination prior to prescribing a drug for medication assisted therapy for a SUD to be conducted through telehealth</p>

conditions triggering section [144.4197](#) or [144.4198, subdivision 2](#), paragraph (b), exist. The commissioner, if a licensed practitioner, or a designated licensed practitioner, may prescribe, dispense, or administer a legend drug or other substance listed in subdivision 10 to control tuberculosis and other communicable diseases. The commissioner may modify state drug labeling requirements, and medical screening criteria and documentation, where time is critical and limited labeling and screening are most likely to ensure legend drugs reach the maximum number of persons in a timely fashion so as to reduce morbidity and mortality.

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

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

- (1) controlled substance drugs listed in section [152.02, subdivisions 3](#) to 5;
 - (2) drugs defined by the Board of Pharmacy as controlled substances under section [152.02, subdivisions 7, 8, and 12](#);
 - (3) muscle relaxants;
 - (4) centrally acting analgesics with opioid activity;
 - (5) drugs containing butalbital; or
 - (6) phosphodiesterase type 5 inhibitors when used to treat erectile dysfunction.
- ~~For purposes of prescribing drugs listed in clause (6), the requirement for a documented patient evaluation, including an examination, may be met through the use of telemedicine, as defined in section [147.033, subdivision 1](#).~~

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

- (1) an in-person examination has been completed in any of the following circumstances:
 - ~~(i)~~ (i) the prescribing practitioner examines the patient at the time the prescription or drug order is issued;
 - ~~(ii)~~ (ii) the prescribing practitioner has performed a prior examination of the patient;
 - ~~(iii)~~ (iii) another prescribing practitioner practicing within the same group or clinic as the prescribing practitioner has examined the patient;
 - ~~(iv)~~ (iv) a consulting practitioner to whom the prescribing practitioner has referred the patient has examined the patient; or
 - ~~(v)~~ (v) the referring practitioner has performed an examination in the case of a consultant practitioner issuing a prescription or drug order when providing services by means of telemedicine; or
- (2) the prescription order is for a drug listed in paragraph (d), clause (6), or for medication assisted therapy for a substance use disorder, and the prescribing practitioner has completed an examination of the patient via telehealth as defined in section [62A.673, subdivision 2, paragraph \(h\)](#).

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Subd. 26. **Telemedicine Telehealth.**

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

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Subdivision 1.

General. Each client must have a person-centered individual treatment plan developed by an alcohol and drug counselor within ten days from the day of service initiation for a residential program and within five calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. The individual treatment plan is developed upon the qualified staff member's dated signature. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the

Sections 4-6:

Make changes in chapter 245G to permit an assessment for SUD to be delivered via telehealth. A client's approval for the SUD treatment plan can also be obtained verbally or electronically if services are being received via telehealth.

client's condition, the client's level of participation, and on whether methods identified have the intended effect. A change to the plan must be signed by the client and the alcohol and drug counselor. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. If a client is receiving treatment services or an assessment via telehealth and the alcohol and drug counselor documents the reason the client's signature cannot be obtained, the alcohol and drug counselor may document the client's verbal approval or electronic written approval of the treatment plan or change to the treatment plan in lieu of the client's signature.

EFFECTIVE DATE. This section is effective July 1, 2021.

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

Subd. 5. Assessment via ~~telemedicine~~ telehealth.

Notwithstanding Minnesota Rules, part [9530.6615](#), subpart 3, item A, a chemical use assessment may be conducted via ~~telemedicine~~ telehealth as defined in section [256B.0625](#), subdivision 3b.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Subd. 5. Rate requirements.

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

(b) Eligible substance use disorder treatment services include:

- (1) outpatient treatment services that are licensed according to sections [245G.01](#) to [245G.17](#), or applicable tribal license;
- (2) comprehensive assessments provided according to sections [245.4863](#), paragraph (a), and [245G.05](#);
- (3) care coordination services provided according to section [245G.07](#), subdivision 1, paragraph (a), clause (5);
- (4) peer recovery support services provided according to section [245G.07](#), subdivision 2, clause (8),
- (5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter [245F](#);
- (6) medication-assisted therapy services that are licensed according to sections [245G.01](#) to [245G.17](#) and [245G.22](#), or applicable tribal license;
- (7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;
- (8) high, medium, and low intensity residential treatment services that are licensed according to sections [245G.01](#) to [245G.17](#) and [245G.21](#) or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;
- (9) hospital-based treatment services that are licensed according to sections [245G.01](#) to [245G.17](#) or applicable tribal license and licensed as a hospital under sections [144.50](#) to [144.56](#);
- (10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections [245G.01](#) to [245G.18](#) or as residential treatment programs according to Minnesota Rules, parts [2960.0010](#) to [2960.0220](#), and [2960.0430](#) to [2960.0490](#), or applicable tribal license;
- (11) high-intensity residential treatment services that are licensed according to sections [245G.01](#) to [245G.17](#) and [245G.21](#) or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

Sections 7-8:

Clarifies that chemical use assessments may be conducted through telehealth

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via ~~two-way interactive video~~ telehealth as defined in section 256B.0625, subdivision 3b. The use of ~~two-way interactive~~

~~video telehealth to deliver services~~ must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. ~~The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.~~

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

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2020, section 256B.0622, subdivision 7a, as amended by Laws 2021, chapter 30, article 17, section 60, is amended to read:

Subd. 7a. Assertive community treatment team staff requirements and roles.

(a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

(i) shall be a mental health professional. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role but must obtain full licensure within 24 months of assuming the role of team leader;

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

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

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

(2) the psychiatric care provider:

(i) must be a mental health professional permitted to prescribe psychiatric medications as part of the mental health professional's scope of practice. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness;

(ii) shall collaborate with the team leader in sharing overall clinical responsibility for screening and admitting clients; monitoring clients' treatment and team member service delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects, and health-related conditions; actively collaborating with nurses; and helping provide treatment supervision to the team;

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

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

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

~~(vi) may not provide specific roles and responsibilities by telemedicine unless approved by the commissioner; and~~

Section 10:

Removes a requirement that a psychiatric provider, as a part of an ACT team, obtain approval from the commissioner when providing services by telemedicine

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

(3) the nursing staff:

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

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

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

psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

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

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

(5) the vocational specialist:

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

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

and

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

(6) the mental health certified peer specialist:

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

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

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

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

(8) additional staff:

(i) shall be based on team size. Additional treatment team staff may include mental health professionals; clinical trainees; certified rehabilitation specialists; mental health practitioners; or mental health rehabilitation workers. These individuals shall have the knowledge, skills, and abilities required by the population served to carry out rehabilitation and support functions; and

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

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

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

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

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

Sec. 11. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, as amended by Laws 2021, chapter 30, article 17, section 71, is amended to read:

Subd. 3b. ~~Telemedicine~~ **Telehealth services.**

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

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

- (1) has identified the categories or types of services the health care provider will provide ~~via telemedicine through telehealth~~;
- (2) has written policies and procedures specific to telemedicine services delivered through telehealth that are regularly reviewed and updated;
- (3) has policies and procedures that adequately address patient safety before, during, and after the ~~telemedicine~~ service is rendered delivered through telehealth;
- (4) has established protocols addressing how and when to discontinue telemedicine services; and
- (5) has an established quality assurance process related to telemedicine delivering services through telehealth.

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

- (1) the type of service ~~provided by telemedicine delivered through telehealth~~;
- (2) the time the service began and the time the service ended, including an a.m. and p.m. designation;
- (3) the ~~licensed~~ health care provider's basis for determining that telemedicine telehealth is an appropriate and effective means for delivering the service to the enrollee;

Section 11:

Modifies the medical assistance coverage requirements for services delivered through telehealth (includes health care services, mental health services, chemical dependency services and SUD services). Major changes include removing the three visit per enrollee per week limit, expanding the provider types eligible to provide telehealth, and making MA coverage consistent in most areas with private sector coverage. Audio-only coverage is still prohibited in the language of this statute, but is covered under MA through an expansion of the DHS waivers in a later section.

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

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

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

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

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

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

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

(1) "telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communication to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Telehealth does not include communication between health care providers, or between a health care provider and a patient that consists solely of an audio-only communication, e-mail, or facsimile transmission or specified by law;

—(e) For purposes of this section, "licensed (2) "health care provider" means a licensed health care provider under section 62A.671, subdivision 6 as defined under section 62A.673, a community paramedic as defined under section 144E.001, subdivision 5f, a clinical trainee who is qualified according to section 245I.04, subdivision 6, a mental health practitioner qualified according to section 245I.04, subdivision 4, and a community health worker who meets the criteria under subdivision 49, paragraph (a); "health care provider" is defined under section 62A.671, subdivision 3, a mental health certified peer specialist under section 56B.0615, subdivision 5, a mental health certified family peer specialist under section 256B.0616, subdivision 5, a mental health rehabilitation worker under section 256B.0623, subdivision 5, paragraph (a), clause (4), and paragraph (b), a mental health behavioral aide under section 256B.0943, subdivision 7, paragraph (b), clause (3), a treatment coordinator under section 245G.11, subdivision 7, an alcohol and drug counselor under section 245G.11, subdivision 5, a recovery peer under section 245G.11, subdivision 8; and

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

2.

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Subd. 3h. Telemonitoring services.

(a) Medical assistance covers telemonitoring services if:

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

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

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained

Section 12:

Extends medical assistance coverage to telemonitoring services.

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

Subd. 13h. Medication therapy management services.

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

(1) performing or obtaining necessary assessments of the patient's health status;
(2) formulating a medication treatment plan, which may include prescribing medications or products in accordance with section [151.37, subdivision 14](#), 15, or 16;
(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

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

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

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

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

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

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

Section 13:

Modifies medication therapy management services to include services delivered through telehealth.

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Subd. 20. **Mental health case management.**

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

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

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

Section 14:

Clarifies that mental health case management services may be provided either in person or through interactive video

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

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

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

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

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

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

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

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

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

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

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

- (1) the costs of developing and implementing this section; and
- (2) programming the information systems.

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

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

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

- (1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or
- (2) the limits and conditions which apply to federal Medicaid funding for this service.

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

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

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Subd. 20b. **Mental health Targeted case management through interactive video.**

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

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

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

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

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

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

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

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

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

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

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

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

Section 15:

Specifies the conditions under which face-to-face contact requirements for targeted case management services may be met through interactive video. TCM services may be conducted through interactive video if it is “in the best interests” of and is deemed appropriate by the patient. The commissioner may, but is no longer required, to establish criteria to which TCM providers must attest to demonstrate the safety/efficacy of delivering their services via telehealth.

<p>(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video <u>for the purpose of face-to-face contact</u>:</p> <p>(1) the time the service <u>contact</u> began and the time the service <u>contact</u> ended, including an a.m. and p.m. designation;</p> <p>(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to <u>contacting</u> the person receiving <u>targeted</u> case management services;</p> <p>(3) the mode of transmission of the interactive video used to deliver the services and records evidencing <u>stating</u> that a particular mode of transmission was utilized; <u>and</u></p> <p>(4) the location of the originating site and the distant site; and,</p> <p>(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (e).</p> <p><u>(e) Interactive video must not be used to meet minimum face-to-face contact requirements for children who are in out-of-home placement or receiving case management services for child protection reasons.</u></p> <p><u>(f) For purposes of this subdivision, "interactive video" means the delivery of targeted case management services in real time through the use of two-way interactive audio and visual communication.</u></p> <p><u>EFFECTIVE DATE.</u> <u>This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.</u></p>	
<p>Sec. 16. Minnesota Statutes 2020, section 256B.0625, subdivision 46, is amended to read:</p> <p>Subd. 46. Mental health telemedicine <u>telehealth</u>.</p> <p>Effective January 1, 2006, and Subject to federal approval, mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via <u>two-way interactive video telehealth in accordance with subdivision 3b</u>. Use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the service. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.</p>	<p>Section 16: Clarifies that mental health services may be provided through telehealth</p>
<p>Sec. 17. Minnesota Statutes 2020, section 256B.0911, subdivision 1a, is amended to read:</p> <p>Subd. 1a. Definitions.</p> <p>For purposes of this section, the following definitions apply:</p> <p>(a) Until additional requirements apply under paragraph (b), "long-term care consultation services" means:</p> <p>(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;</p> <p>(2) providing recommendations for and referrals to cost-effective community services that are available to the individual;</p> <p>(3) development of an individual's person-centered community support plan;</p> <p>(4) providing information regarding eligibility for Minnesota health care programs;</p> <p>(5) face-to-face long-term care consultation assessments <u>conducted according to subdivision 3a</u>, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;</p> <p>(6) determination of home and community-based waiver and other service eligibility as required under chapter 256S and sections <u>256B.0913, 256B.092, and 256B.49</u>, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on a long-term care consultation assessment and community support plan development, appropriate referrals to obtain necessary diagnostic</p>	<p>Sections 17-19: Allows long-term care consultation reassessments to be provided through interactive video or telephone if specified requirements are met, including that the patient is being reassessed OR the patient's legal representative and lead agency case manager agree that there is no change in the patient's condition.</p>

information, and including an eligibility determination for consumer-directed community supports;

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

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

(9) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Hub and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made. For the purposes of this subdivision, "competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities;

(10) providing information about independent living to ensure that an informed choice about independent living can be made; and

(11) providing information about self-directed services and supports, including self-directed funding options, to ensure that an informed choice about self-directed options can be made.

(b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c, and 3a, "long-term care consultation services" also means:

(1) service eligibility determination for the following state plan services:

(i) personal care assistance services under section [256B.0625, subdivisions 19a](#) and 19c;

(ii) consumer support grants under section [256.476](#); or

(iii) community first services and supports under section [256B.85](#);

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, gaining access to:

(i) relocation targeted case management services available under section [256B.0621, subdivision 2](#), clause (4);

(ii) case management services targeted to vulnerable adults or developmental disabilities under section [256B.0924](#); and

(iii) case management services targeted to people with developmental disabilities under Minnesota Rules, part 9525.0016;

(3) determination of eligibility for semi-independent living services under section [252.275](#); and

(4) obtaining necessary diagnostic information to determine eligibility under clauses (2) and (3).

(c) "Long-term care options counseling" means the services provided by sections [256.01, subdivision 24](#), and [256.975, subdivision 7](#), and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(d) "Minnesota health care programs" means the medical assistance program under this chapter and the alternative care program under section [256B.0913](#).

(e) "Lead agencies" means counties administering or tribes and health plans under contract with the commissioner to administer long-term care consultation services.

(f) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives, the settings in which the person receives the services, and the setting in which the person lives.

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

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

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

Sec. 18. Minnesota Statutes 2020, section 256B.0911, subdivision 3a, as amended by Laws 2021, chapter 30, article 12, section 2, is amended to read:

Subd. 3a. Assessment and support planning.

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

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

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

(d) Except as provided in paragraph (r), the assessment must be conducted by a certified assessor in a face-to-face conversational interview with the person being assessed. The person's legal representative must provide input during the assessment process and may do so remotely if requested. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under chapter 256S, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section [256B.092](#) or [256B.49](#), with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs the person completed in consultation with someone who is known to the person and has interaction with the person on a regular basis. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

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

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

(g) The written community support plan must include:

- (1) a summary of assessed needs as defined in paragraphs (c) and (d);
- (2) the individual's options and choices to meet identified needs, including:

- (i) all available options for case management services and providers;
 - (ii) all available options for employment services, settings, and providers;
 - (iii) all available options for living arrangements;
 - (iv) all available options for self-directed services and supports, including self-directed budget options; and
 - (v) service provided in a non-disability-specific setting;
- (3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;
- (4) referral information; and
 - (5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(h) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections [256.975, subdivision 7](#), and [256.01](#), subdivision 24, for telephone assistance and follow up.

(i) The person has the right to make the final decision:

(1) between institutional placement and community placement after the recommendations have been provided, except as provided in section [256.975](#), subdivision 7a, paragraph (d);

(2) between community placement in a setting controlled by a provider and living independently in a setting not controlled by a provider;

(3) between day services and employment services; and

(4) regarding available options for self-directed services and supports, including self-directed funding options.

(j) The lead agency must give the person receiving long-term care consultation services or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under chapter 256S or section [256B.49](#), "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section [256.975, subdivisions 7a to 7c](#), if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

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

(5) information about Minnesota health care programs;

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

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

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

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a),

clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section [256.045, subdivision 3](#). The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated; and

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

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

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

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

(n) If a person who receives home and community-based waiver services under section [256B.0913](#), [256B.092](#), or [256B.49](#) or chapter 256S temporarily enters for 121 days or fewer a hospital, institution of mental disease, nursing facility, intensive residential treatment services program, transitional care unit, or inpatient substance use disorder treatment setting, the person may return to the community with home and community-based waiver services under the same waiver, without requiring an assessment or reassessment under this section, unless the person's annual reassessment is otherwise due. Nothing in this paragraph shall change annual long-term care consultation reassessment requirements, payment for institutional or treatment services, medical assistance financial eligibility, or any other law.

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

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

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

(r) All assessments performed according to this subdivision must be face-to-face unless the assessment is a reassessment meeting the requirements of this paragraph. Remote reassessments conducted by interactive video or telephone may substitute for face-to-face reassessments. For services provided by the developmental disabilities waiver under section 256B.092, and the community access for disability inclusion, community

alternative care, and brain injury waiver programs under section 256B.49, remote reassessments may be substituted for two consecutive reassessments if followed by a face-to-face reassessment. For services provided by alternative care under section 256B.0913, essential community supports under section 256B.0922, and the elderly waiver under chapter 256S, remote reassessments may be substituted for one reassessment if followed by a face-to-face reassessment. A remote reassessment is permitted only if the person being reassessed, or the person's legal representative, and the lead agency case manager both agree that there is no change in the person's condition, there is no need for a change in service, and that a remote reassessment is appropriate. The person being reassessed, or the person's legal representative, has the right to refuse a remote reassessment at any time. During a remote reassessment, if the certified assessor determines a face-to-face reassessment is necessary in order to complete the assessment, the lead agency shall schedule a face-to-face reassessment. All other requirements of a face-to-face reassessment shall apply to a remote reassessment, including updates to a person's support plan.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 19. Minnesota Statutes 2020, section 256B.0911, subdivision 3f, is amended to read:

Subd. 3f. Long-term care reassessments and community support plan updates.

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

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

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

Subd. 6. Payment for targeted case management.

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

(b) Payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of

Section 20:

Adds language to clarify that targeted case management services can be delivered through interactive video. Specifies the requirements for payment for targeted case management for adults when contact is through interactive video.

December 31, 2001. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

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

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

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

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

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

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

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

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

- (1) the last 180 days of the recipient's residency in that facility; or
- (2) the limits and conditions which apply to federal Medicaid funding for this

service.

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

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

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Subd. 6. Medical assistance reimbursement of case management services.

(a) Medical assistance reimbursement for services under this section shall be made on a monthly basis. Payment is based on face-to-face contacts either in person or by interactive video, or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the

Section 21:

Adds language to clarify that child welfare targeted case management services can be delivered through interactive video. Specifies the requirements for payment for child welfare targeted case management

<p>status of the client, the individual service plan, or the goals for the client. These contacts must meet the minimum standards in clauses (1) and (2) following requirements:</p> <p>(1) there must be a face-to-face contact <u>either in person or by interactive video that meets the requirements of section 256B.0625, subdivision 20b</u>, at least once a month except as provided in clause (2); and</p> <p>(2) for a client placed outside of the county of financial responsibility, or a client served by tribal social services placed outside the reservation, in an excluded time facility under section <u>256G.02, subdivision 6</u>, or through the Interstate Compact for the Placement of Children, section <u>260.93</u>, and the placement in either case is more than 60 miles beyond the county or reservation boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face, <u>in-person</u> contact.</p> <p>(b) Except as provided under paragraph (c), the payment rate is established using time study data on activities of provider service staff and reports required under sections <u>245.482</u> and <u>256.01, subdivision 2</u>, paragraph (p).</p> <p>(c) Payments for tribes may be made according to section <u>256B.0625</u> or other relevant federally approved rate setting methodology for child welfare targeted case management provided by Indian health services and facilities operated by a tribe or tribal organization.</p> <p>(d) Payment for case management provided by county or tribal social services contracted vendors shall be based on a monthly rate negotiated by the host county or tribal social services. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribal social services may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribal social services, except to reimburse the county or tribal social services for advance funding provided by the county or tribal social services to the vendor.</p> <p>(e) If the service is provided by a team that includes contracted vendors and county or tribal social services staff, the costs for county or tribal social services staff participation in the team shall be included in the rate for county or tribal social services provided services. In this case, the contracted vendor and the county or tribal social services may each receive separate payment for services provided by each entity in the same month. To prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles and services of the team members. Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study, or under paragraph (c), shall be distributed according to earnings, to counties, reservations, or groups of counties or reservations which have the same payment rate under this subdivision, and to the group of counties or reservations which are not certified providers under section <u>256F.10</u>. The commissioner shall modify the requirements set out in Minnesota Rules, parts <u>9550.0300</u> to <u>9550.0370</u>, as necessary to accomplish this.</p> <p><u>EFFECTIVE DATE.</u> <u>This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.</u></p>	<p>services when contact is through interactive video.</p>
<p>Sec. 22. Minnesota Statutes 2020, section 256B.0943, subdivision 1, as amended by Laws 2021, chapter 30, article 17, section 81, is amended to read:</p> <p>Subdivision 1. Definitions.</p> <p>For purposes of this section, the following terms have the meanings given them.</p> <p>(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed emotional disturbance, as defined in section <u>245.4871, subdivision 15</u>, or a diagnosed mental illness, as defined in section <u>245.462</u>, subdivision 20. The services are time-limited interventions that are delivered using various treatment</p>	<p>Section 22: Changes the terminology to refer to telehealth (formerly "telemedicine") in a section of law dealing with children's therapeutic services</p>

modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(b) "Clinical trainee" means a staff person who is qualified according to section [245I.04, subdivision 6](#).

(c) "Crisis planning " has the meaning given in section [245.4871, subdivision 9a](#).

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

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

(f) " Standard diagnostic assessment" means the assessment described in [245I.10, subdivision 6](#).

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

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

(i) "Emotional disturbance" has the meaning given in section [245.4871, subdivision 15](#).

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

(k) "Individual treatment plan" means the plan described in section [245I.10, subdivisions 7 and 8](#).

(l) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a mental health behavioral aide qualified according to section [245I.04, subdivision 16](#), to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(m) "Mental health certified family peer specialist" means a staff person who is qualified according to section [245I.04, subdivision 12](#).

(n) "Mental health practitioner" means a staff person who is qualified according to section [245I.04, subdivision 4](#).

(o) "Mental health professional" means a staff person who is qualified according to section [245I.04, subdivision 2](#).

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

(1) the development, review, and revision of a child's individual treatment plan, including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) administering and reporting the standardized outcome measurements in section [245I.10, subdivision 6](#), paragraph (d), clauses (3) and (4), and other standardized outcome measurements approved by the commissioner, as periodically needed to evaluate the effectiveness of treatment.

<p>(q) "Mental illness," for persons at least age 18 but under age 21, has the meaning given in section 245.462, subdivision 20, paragraph (a).</p> <p>(r) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.</p> <p>(s) "Rehabilitative services" or "psychiatric rehabilitation services" means interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement.</p> <p>(t) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).</p> <p>(u) "Treatment supervision" means the supervision described in section 245I.06.</p>	
<p>Sec. 23. Minnesota Statutes 2020, section 256B.0949, subdivision 13, is amended to read:</p> <p>Subd. 13. Covered services.</p> <p>(a) The services described in paragraphs (b) to (l) are eligible for reimbursement by medical assistance under this section. Services must be provided by a qualified EIDBI provider and supervised by a QSP. An EIDBI service must address the person's medically necessary treatment goals and must be targeted to develop, enhance, or maintain the individual developmental skills of a person with ASD or a related condition to improve functional communication, including nonverbal or social communication, social or interpersonal interaction, restrictive or repetitive behaviors, hyperreactivity or hyporeactivity to sensory input, behavioral challenges and self-regulation, cognition, learning and play, self-care, and safety.</p> <p>(b) EIDBI treatment must be delivered consistent with the standards of an approved modality, as published by the commissioner. EIDBI modalities include:</p> <ol style="list-style-type: none"> (1) applied behavior analysis (ABA); (2) developmental individual-difference relationship-based model (DIR/Floortime); (3) early start Denver model (ESDM); (4) PLAY project; (5) relationship development intervention (RDI); or (6) additional modalities not listed in clauses (1) to (5) upon approval by the commissioner. <p>(c) An EIDBI provider may use one or more of the EIDBI modalities in paragraph (b), clauses (1) to (5), as the primary modality for treatment as a covered service, or several EIDBI modalities in combination as the primary modality of treatment, as approved by the commissioner. An EIDBI provider that identifies and provides assurance of qualifications for a single specific treatment modality must document the required qualifications to meet fidelity to the specific model.</p> <p>(d) Each qualified EIDBI provider must identify and provide assurance of qualifications for professional licensure certification, or training in evidence-based treatment methods, and must document the required qualifications outlined in subdivision 15 in a manner determined by the commissioner.</p> <p>(e) CMDE is a comprehensive evaluation of the person's developmental status to determine medical necessity for EIDBI services and meets the requirements of subdivision 5. The services must be provided by a qualified CMDE provider.</p> <p>(f) EIDBI intervention observation and direction is the clinical direction and oversight of EIDBI services by the QSP, level I treatment provider, or level II treatment provider, including developmental and behavioral techniques, progress measurement, data collection,</p>	<p>Section 23: Specifies that travel time is only an allowable billing for early intensive developmental and behavioral intervention (EIDBI) benefits for persons with autism spectrum disorder when providing in-person services and makes conforming changes in terminology</p>

<p>function of behaviors, and generalization of acquired skills for the direct benefit of a person. EIDBI intervention observation and direction informs any modification of the current treatment protocol to support the outcomes outlined in the ITP.</p> <p>(g) Intervention is medically necessary direct treatment provided to a person with ASD or a related condition as outlined in their ITP. All intervention services must be provided under the direction of a QSP. Intervention may take place across multiple settings. The frequency and intensity of intervention services are provided based on the number of treatment goals, person and family or caregiver preferences, and other factors. Intervention services may be provided individually or in a group. Intervention with a higher provider ratio may occur when deemed medically necessary through the person's ITP.</p> <p>(1) Individual intervention is treatment by protocol administered by a single qualified EIDBI provider delivered face-to-face to one person.</p> <p>(2) Group intervention is treatment by protocol provided by one or more qualified EIDBI providers, delivered to at least two people who receive EIDBI services.</p> <p>(h) ITP development and ITP progress monitoring is development of the initial, annual, and progress monitoring of an ITP. ITP development and ITP progress monitoring documents provide oversight and ongoing evaluation of a person's treatment and progress on targeted goals and objectives and integrate and coordinate the person's and the person's legal representative's information from the CMDE and ITP progress monitoring. This service must be reviewed and completed by the QSP, and may include input from a level I provider or a level II provider.</p> <p>(i) Family caregiver training and counseling is specialized training and education for a family or primary caregiver to understand the person's developmental status and help with the person's needs and development. This service must be provided by the QSP, level I provider, or level II provider.</p> <p>(j) A coordinated care conference is a voluntary face-to-face meeting with the person and the person's family to review the CMDE or ITP progress monitoring and to integrate and coordinate services across providers and service-delivery systems to develop the ITP. This service must be provided by the QSP and may include the CMDE provider or a level I provider or a level II provider.</p> <p>(k) Travel time is allowable billing for traveling to and from the person's home, school, a community setting, or place of service outside of an EIDBI center, clinic, or office from a specified location to provide face-to-face <u>in-person</u> EIDBI intervention, observation and direction, or family caregiver training and counseling. The person's ITP must specify the reasons the provider must travel to the person.</p> <p>(l) Medical assistance covers medically necessary EIDBI services and consultations delivered by a licensed health care provider via telemedicine <u>telehealth</u>, as defined under section 256B.0625, subdivision 3b, in the same manner as if the service or consultation was delivered in person.</p>	
<p>Sec. 24. Minnesota Statutes 2020, section 256B.49, subdivision 14, is amended to read:</p> <p>Subd. 14. Assessment and reassessment.</p> <p>(a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.</p> <p>(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and subsequent assessments to initiate and maintain participation in the waiver program.</p> <p>(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.</p> <p>(d) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.</p>	<p>Section 24: Permits remote (telehealth) assessments for community-based service waivers for persons with disabilities</p>
<p>Sec. 25. Minnesota Statutes 2020, section 256S.05, subdivision 2, is amended to read:</p>	<p>Section 25:</p>

<p>Subd. 2. Nursing facility level of care determination required.</p> <p>Notwithstanding other assessments identified in section 144.0724, subdivision 4, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3, 3a, and 3b, that result in a nursing facility level of care determination at initial and subsequent assessments shall be accepted for purposes of a participant's initial and ongoing participation in the elderly waiver and a service provider's access to service payments under this chapter.</p>	<p>Permits remote (telehealth) assessments to be used for determining eligibility for services under the elderly waiver</p>
<p><u>Sec. 26. COMMISSIONER OF HUMAN SERVICES; EXTENSION OF COVID-19 HUMAN SERVICES PROGRAM MODIFICATIONS.</u></p> <p><u>Notwithstanding Laws 2020, First Special Session chapter 7, section 1, subdivision 2, as amended by Laws 2020, Third Special Session chapter 1, section 3, when the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, the following modifications issued by the commissioner of human services pursuant to Executive Orders 20-11 and 20-12, and including any amendments to the modification issued before the peacetime emergency expires, shall remain in effect until July 1, 2023:</u></p> <p><u>(1) CV16: expanding access to telemedicine services for Children's Health Insurance Program, Medical Assistance, and MinnesotaCare enrollees; and</u></p> <p><u>(2) CV21: allowing telemedicine alternative for school-linked mental health services and intermediate school district mental health services.</u></p>	<p>Section 26:</p> <p>This new section extends the modifications and waivers that involve expanding access to services using telehealth that were ordered by the commissioner of human services in response to the governor's peacetime emergency order until June 30, 2023. This has the effect of allowing audio-only telehealth services to continue under MA and MinnesotaCare through that date (6/30/21).</p>
<p><u>Sec. 27. STUDIES OF TELEHEALTH EXPANSION AND PAYMENT PARITY.</u></p> <p><u>(a) The commissioner of health, in consultation with the commissioners of human services and commerce, shall study the impact of telehealth expansion and payment parity under this article on the coverage and provision of health care services under private sector health insurance.</u></p> <p><u>(b) The commissioner of human services, in consultation with the commissioners of health and commerce, shall study the impact of telehealth expansion and payment parity under this article on the coverage and provision of health care services under public health care programs.</u></p> <p><u>(c) The studies required under paragraphs (a) and (b) must review and make recommendations relating to:</u></p> <p><u>(1) the impact of telehealth expansion and payment parity on access to health care services, quality of care, health outcomes, patient satisfaction, and value-based payments and innovation in health care delivery;</u></p> <p><u>(2) the impact of telehealth expansion and payment parity on reducing health care disparities and providing equitable access to health care services for underserved communities;</u></p> <p><u>(3) whether audio-only communication as a permitted option for delivering services (i) supports equitable access to health care services, including behavioral health services, for the elderly, rural communities, and communities of color, and (ii) eliminates barriers to care for vulnerable and underserved populations without reducing the quality of care, worsening health outcomes, or decreasing satisfaction with care;</u></p> <p><u>(4) the services and populations, if any, for which increased access to telehealth improves or negatively impacts health outcomes;</u></p> <p><u>(5) the extent to which services provided through telehealth:</u></p> <p><u>(i) substitute for an in-person visit;</u></p> <p><u>(ii) are services that were previously not billed or reimbursed; or</u></p> <p><u>(iii) are in addition to or are duplicative of services that the patient has received or will receive as part of an in-person visit;</u></p> <p><u>(6) the effect of telehealth expansion and payment parity on public and private sector health care costs, including health insurance premiums; and</u></p> <p><u>(7) the impact of telehealth expansion and payment parity, especially in rural areas, on patient access to, and the availability of, in-person care, including specialty care.</u></p> <p><u>(d) In addition, the studies must report:</u></p>	<p>Section 27:</p> <p>This new section requires the commissioners of health and human services to each study the impact of telehealth payment methodologies and delivery expansion on the coverage and provision of services delivered through telehealth. It requires the commissioners to present preliminary reports to the legislature by January 15, 2023 (which must include recommendations on whether audio-only communication should continue to be allowed) and final reports by January 15, 2024.</p>

<p><u>(1) the criteria payers used during the study period to determine which patients were medically appropriate to be served through telehealth, and which categories of service were medically appropriate to be delivered through telehealth, including but not limited to the use of audio-only communication; and</u></p> <p><u>(2) the methods payers used to ensure that patients were allowed to choose to receive a service through telehealth or in person during the study period.</u></p> <p><u>(e) When conducting the studies, the commissioners shall consult with public program enrollees and other patients, providers, communities impacted by telehealth expansion and payment parity, and other stakeholders. Notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, the commissioners may use data available under that section to conduct the studies and may consult with experts in payment policy and health care delivery. Health plan companies shall submit information requested by the commissioners for purposes of the studies in the form and manner specified by the commissioners.</u></p> <p><u>(f) The commissioners shall present a preliminary report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and commerce by January 15, 2023. The preliminary report must include qualitative and any available quantitative findings, and recommendations on whether audio-only communication should be allowed as a telehealth option beyond June 30, 2023. The commissioners shall present a final report to the chairs and ranking minority members of these specified legislative committees by January 15, 2024.</u></p>	
<p>Sec. 28. <u>REVISOR INSTRUCTION.</u></p> <p><u>In Minnesota Statutes and Minnesota Rules, the revisor of statutes shall substitute the term "telemedicine" with "telehealth" whenever the term appears and substitute Minnesota Statutes, section 62A.673, whenever references to Minnesota Statutes, sections 62A.67, 62A.671, and 62A.672 appear.</u></p>	<p>Section 28: Substitutes the term “telehealth” for “telemedicine” in all Minnesota Statutes and Rules. Replaces 62A.67, 62A.671, and 62A.672 with 62A.673.</p>
<p>Sec. 29. <u>REPEALER.</u></p> <p><u>(a) Minnesota Statutes 2020, sections 62A.67; 62A.671; and 62A.672, are repealed effective July 1, 2021.</u></p> <p><u>(b) Minnesota Statutes 2020, sections 256B.0596; and 256B.0924, subdivision 4a, are repealed effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.</u></p> <p><u>(c) Laws 2021, chapter 30, article 17, section 71, is repealed effective the day following final enactment.</u></p>	<p>Section 29: Repealer. Repeals current law governing private sector telemedicine services, and provisions related to case management and licensed providers</p>

ARTICLE 11: BEHAVIORAL HEALTH

<i>Text of the legislation</i>	<i>Summary of changes to telehealth</i>
<p>Sec. 11. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:</p> <p>Subd. 5. Rate requirements.</p> <p>(a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.</p> <p>(b) Eligible substance use disorder treatment services include:</p> <p>(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;</p> <p>(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;</p> <p>(3) care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);</p> <p>(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);</p>	<p>Section 11: Removes higher rates for certain SUD treatment services and providers. Adds culturally responsive and disability responsive programs as qualifying facilities. Modifies telehealth requirements.</p>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) culturally specific or culturally responsive programs as defined in section [254B.01, subdivision 4a](#), ~~or~~;

(3) disability responsive programs as defined in section [254B.01, subdivision 4b](#);

~~programs or subprograms serving special populations, if the program or subprogram meets the following requirements:~~

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

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

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

~~(3)~~ (4) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; ~~and~~ or

~~(4)~~ (5) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

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

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

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

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

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

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

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

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

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

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

(h) Payment for outpatient substance use disorder services that are licensed according to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless prior authorization of a greater number of hours is obtained from the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later.