Bill Summary Comparison of Health and Human Services

House File 2128-4	Senate File UEH2128-1
Article 7: Telehealth	**Article 8: Telehealth**

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1	**Coverage of services provided through telehealth.** Adds § 62A.673. Establishes requirements for the coverage of telehealth by health carriers. This section incorporates language from telemedicine requirements in sections 62A.67 to 62A.672 (these sections are repealed in the bill) and provisions from Laws 2020, chapter 74, as well as new language. **Subd. 1. Citation.** States that this section may be cited as the "Minnesota Telehealth Act." **Subd. 2. Definitions.** Defines the following terms: distant site, health care provider, health carrier, health plan, originating site, store-and-forward transfer, and telehealth. These definitions are modifications of those in current law in § 62A.671. Major differences include: ▪ The definition of "health care provider" includes mental health practitioners (one of the groups added temporarily in chapter 74) and also treatment coordinators, alcohol and drug counselors, and recovery peers. ▪ The definition of "telehealth" is a revision of the definition of "telemedicine" in current law. The revised definition specifically includes "audio-only communication between a health care provider and a patient" if this is a scheduled appointment and the standard of care can be met; this is not explicit in current law. ▪ Provides a definition of "telemonitoring services;" this term is not defined in current law.	**Subdivision 1 (Page R1)**: Identical **Subd. 2 (Page R1):** Differences • House refers to "store and forward transfer"; Senate refers to "store and forward technology" and adds "or transmission". • Senate states that telemonitoring is not included in the definition of telehealth. • Minor technical difference (staff recommends Senate)	**Section 1 (62A.673)** rewrites the current telehealth coverage statute by changing the terminology form telemedicine to telehealth and by clarifying definitions and coverage requirements. **Subdivision 1** permits the section to be cited as the "Minnesota Telehealth Act" (current law). **Subd. 2** defines the following terms: distant site; health care provider; health carrier; health plan; originating site; store and forward technology; and telehealth. The changes to current law are as follows: • Definition of health care provider means any licensed or registered health care provider practicing within their scope of practice in accordance with state law and includes mental health professionals and mental health practitioners, and for services provided by a chapter 245G facility, treatment coordinators, alcohol and drug counselors, and recovery peers. • Definition of originating site clarifies that this means the site at which the patient is located at the time the health care services are provided to the patient through telehealth and clarifies that for purposes of store-and-forward, it means the location at which the health care provider transfers or transmits information to a distant site. • Definition of store-and-forward clarifies that this

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			means the asynchronous electronic transfer of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient. • Definition of telehealth is modified to include the use of real-time two-way interactive audio and visual or audio only communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. It specifies that telehealth includes audio only communication between a health care provider and patient 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 and specifies that telehealth does not include communication between health care providers or a healthcare provider and patient that consists solely of an email or fax. • Adds a definition for telemonitoring services.
	Subd. 3. Coverage of telehealth. (a) Requires health plans to cover benefits delivered through telehealth in the same manner as any other benefits, and to comply with this section. (Similar to language in § 62A.672.) (b) Prohibits coverage of telehealth services from being limited on the basis of geography, location, or distance for travel. (New provision.)	**Subd. 3 (Page R2):** Differences • **Paragraph (b):** Senate adds that this paragraph is subject to the provider network being available to the enrollee through the enrollee's health plan. • **Paragraph (c):** House specifies that a health carrier must not provide incentives to enrollees to use a separate provider network; Senate specifies that a health carrier must not require an enrollee to use a	**Subd. 3** specifies the coverage of services delivered through telehealth. The changes from current law are as follows: • **Paragraph (b)** specifies that coverage for services delivered through telehealth must not be limited based on geography, location, or distance of travel, subject to the provider network available to the enrollee through the enrollee's health plan.

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	(c) Prohibits a health carrier from creating a separate provider network or providing incentives for enrollees to use a separate provider network to deliver telehealth services, if this network does not include network providers who provide in-person care for the same service. (New provision.) (d) Allows a health carrier to include cost-sharing for a service provided through telehealth, if this cost-sharing is not in addition to, and does not exceed, cost-sharing for the same service provided in-person. (Similar to language in § 62A.67.) (e) States that nothing in this section shall be construed to: (1) require a health carrier to provide coverage for services that are not medically necessary or not covered under the enrollee's health plan; or (2) prohibit a health carrier from: (i) establishing safety and efficacy criteria for a particular telehealth service for which other providers are not already reimbursed under telehealth; (ii) establishing reasonable medical management techniques; or (iii) requiring documentation or billing practices designed to prevent fraudulent claims. (Item (ii) and the reference in clause (1) to services covered under a health plan are new; the other provisions in this paragraph are similar to language in § 62A.672.)	specific provider within the network to receive services by telehealth (connected to Senate's paragraph (b)). • **Paragraph (e):** technical differences (staff recommends House)	• **Paragraph (c)** prohibits a health carrier from creating 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 requiring an enrollee to use a specific provider within the network to receive services through telehealth. • **Paragraph (e)** specifies that nothing in this section prohibits a health carrier from establishing reasonable medical management techniques, so long as the techniques are not unduly burdensome or unreasonable for that service. • **Paragraph (f)** specifies that nothing in this section shall be construed to require the use of telehealth when a provider determines that the delivery of the service through telehealth is not appropriate or when an enrollee chooses not to receive a health care service through telehealth.

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	(f) States that nothing in this section shall be construed to require the use of telehealth when a provider determines this is not appropriate or the enrollee chooses not to receive a health care service through telehealth. (New provision.) **Subd. 4. Parity between telehealth and in-person services.** (a) Prohibits a health carrier from restricting or denying coverage of a covered health care service solely: (1) because the service is not provided in-person; or (2) based on the communication technology or application used to deliver the service through telehealth, provided the technology or application complies with this section and is appropriate for the particular service. (Clause (1) is similar to language in § 62A.672; clause (2) is new.) (b) Allows prior authorization to be used for a telehealth service only if it is required when the same service is delivered in-person. (New provision.) (c) Allows a health carrier to require utilization review for a service delivered through telehealth so long as it is conducted in the same manner and uses the same clinical review criteria as utilization review for the same service delivered in-person. (New provision.)	**Subd. 4 (Page R3)**: Difference: • Senate adds a paragraph (d) stating that a carrier or provider shall not require an enrollee to pay a fee to use a specific communication technology or application.	**Subd. 4** clarifies the parity requirements between services delivered in person and through telehealth. The changes to current law are as follows: • **Paragraph (a)** specifies that a health carrier must not restrict or deny coverage of a service that is covered under a health plan solely based on the communication technology or application used to deliver the service through telehealth so long as the technology or application complies with this section and is appropriate for the particular service. • **Paragraph (b)** specifies that prior authorization may be required for services delivered through telehealth but only if prior authorizations are required before the delivery of the same service through in-person contact. • **Paragraph (c)** specifies that utilization review may be required for services delivered through telehealth provided that the review is conducted in the same manner and uses the same criteria as a review for the same service delivered through in person contact. • **Paragraph (d)** prohibits a health carrier or provider from requiring an enrollee to pay a fee to

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	Subd. 5. Reimbursement for services delivered through telehealth. (a) Requires health carriers to reimburse providers for telehealth services on the same basis and at the same rate as would apply had the service been delivered in-person. (Similar to language in § 62A.672.) (b) Prohibits a health carrier from denying or limiting reimbursement solely because the service was delivered though telehealth rather than in-person. (Similar to temporary language in chapter 74.) (c) Prohibits a health carrier from denying or limiting reimbursement based solely on the technology and equipment used by the health care provider to deliver the service through telehealth, as long as the technology and equipment meets the requirements of this section and is appropriate for the particular service. (Similar to temporary language in chapter 74.)	**Subd. 5 (Page R3):** Identical	download a specific communication technology or application. **Subd. 5** clarifies the parity reimbursement requirements between services delivered in person and through telehealth. The changes to current law are as follows: • **Paragraph (b)** specifies that a health carrier may not deny or limit reimbursement based solely on a provider delivering the service through telehealth instead of through in-person contact. • **Paragraph (c)** specifies that a health carrier may not deny or limit reimbursement based solely on the technology and equipment used by the provider to deliver the service through telehealth, provided that the technology and equipment used meets the requirements of this section and is appropriate for the particular service.
	Subd. 6. Telehealth equipment. (a) Prohibits a health carrier from requiring a provider to use specific telecommunications technology and equipment as a condition of coverage, as long as this technology and equipment complies with current industry interoperable standards and with federal Health Insurance Portability and Accountability Act (HIPAA) standards and regulations, unless authorized under this section. (b) Requires a health carrier to cover services delivered through telehealth by audio-only telephone communication, if this communication is a result of a	**Subd. 6 (Page R3):** Differences • Senate adds a paragraph (c), creating an exception to the audio-only communications requirement that it must be a scheduled appointment, for mental health and substance use disorder services if the audio-only communication is initiated by the enrollee, while in an emergency or crisis situation and a scheduled appointment was not possible.	**Subd. 6, paragraph (a)** prohibits a health carrier from requiring a provider to use specific telecommunication technology or equipment as a condition of coverage provided that the technology and equipment the provider uses complies with current industry interoperable standards and complies with standards required under HIPPA, unless authorized under this section. • **Paragraph (b)** clarifies that telehealth coverage includes the use of audio only communication, provided the communication is a scheduled appointment and the standard of care for that

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	scheduled appointment and the standard of care for the particular service can be met through audio-only communication. (The provisions in this subdivision are new.) **Subd. 7. Telemonitoring services.** Requires a health carrier to provide coverage for telemonitoring services if: (1) the services are medically appropriate for the enrollee; (2) the enrollee is capable of operating the monitoring device or equipment, or has a caregiver willing and able to assist; and (3) the enrollee resides in a setting suitable for telemonitoring and not in a setting with health care staff on site. (The provisions in this subdivision are new.) Provides an effective date of January 1, 2022.	• Minor difference: House refers to "audio-only telephone communication"; Senate refers to "audio-only communication." (Staff recommends Senate.) **Subd. 7 (Page R4):** Identical **Subd. 8 (Page R4):** Senate only **Effective Date for Section 1:** • House: January 1, 2022* • Senate: July 1, 2021	service can be met using audio only communication. • **Paragraph (c)** creates an exception to paragraph (b) for mental health and substance use disorder treatment services if the audio only communication was initiated by the enrollee while in an emergency or crisis situation. **Subd. 7** requires a health carrier to provide coverage for telemonitoring services if (1) the service is medically appropriate based on the enrollee's medical condition or status; (2) the enrollee is cognitively and physically capable of operating the monitoring device or equipment or has a caregiver who can; and (3) the enrollee resides in a setting that is suitable for telemonitoring and is not in a setting that has health care staff on site. **Subd. 8** specifies that this section does not apply to coverage provided to state public health care program enrollees under medical assistance and MinnesotaCare programs.
2	**Practice of telehealth.** Amends § 147.033. Modifies telehealth provisions in the physician licensure statute. **Subd. 1. Definition.** Changes terminology from "telemedicine" to "telehealth" and modifies definition to be consistent with the definition in § 62A.673.	**Page R4:** Identical except for effective date. • House: January 1, 2022* • Senate: July 1, 2021	**Section 2 (147.033)** makes conforming changes by changing terminology and cross-references regarding telehealth in the physician licensure chapter.

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	Subd. 2. Physician-patient relationship. Modifies terminology from "telemedicine" to "telehealth." **Subd. 3. Standards of practice and conduct.** Modifies terminology from "telemedicine" to "telehealth." States that this section is effective January 1, 2022.		
3	**Prescribing and filing.** Amends § 151.37, subd. 2. Reorganizes provision relating to examination requirement for licensed practitioners prescribing certain drugs; specifies drugs for which an examination via telehealth meets the requirements. States that this section is effective January 1, 2022.	**Page R5:** Identical except for effective date. • House: January 1, 2022* • Senate: Day following final enactment	**Section 3 (151.37, subd. 2)** specifies that when a practitioner prescribes a drug used for medication assisted therapy for a substance use disorder, the required examination of the patient may be completed via telehealth.
4	**Face-to-face.** Amends § 245G.01, subd. 13. Modifies definition of "face-to-face" in the substance use disorder treatment program licensing chapter, to clarify that services delivered via telehealth should prioritize using combined audio and visual communication. Requires meetings to prescribe high dose medications to treat opioid use disorder to be conducted by interactive video and visual communication. States that this section is effective January 1, 2022, or upon federal approval, whichever is later.	**Page R8:** Identical except House adds for services delivered by telehealth, that priority must be given to interactive audio and visual communication, if available, and meetings required under section 245G.22, subd. 4 must be conducted by interactive audio and visual communication. **Effective Date:** • House: January 1, 2022, or upon federal approval, whichever is later.* • Senate: July 1, 2021.	**Sections 4-6 (245G.01, subd. 13, 26; and 245G.06, subd. 1)** make changes within this chapter clarifying that a comprehensive assessment for substance use disorder may be delivered in person or via telehealth. These sections also specify that if a client receives treatment services and an assessment via telehealth, the alcohol and drug counselor may document the client's verbal approval of the treatment plan or change to the plan in lieu of the client's signature.

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5	**Telehealth.** Amends § 245G.01, subd. 26. Modifies terminology to "telehealth" and definition for "telemedicine" in the substance use disorder treatment program licensing chapter. States that this section is effective January 1, 2022.	**Page R8:** Identical except for effective date. • House: January 1, 2022* • Senate: July 1, 2021	
6	**General.** Amends § 245G.06, subd. 1. Allows an alcohol and drug counselor to document a client's approval of a treatment plan verbally or electronically, in lieu of a signature, if a client is receiving services or an assessment via telehealth. States that this section is effective January 1, 2022.	**Page R8:** Identical except that House refers to "license holder" and permits the license holder to document the client's verbal approval or electronic written approval while Senate refers to "alcohol and drug counselor" and only includes "client's verbal approval." **Effective Date:** • House: January 1, 2022* • Senate: July 1, 2021	
7	**Assessment via telehealth.** Amends § 254A.19, subd. 5. Adds cross-reference to definition of telehealth. States that this section is effective January 1, 2022, or upon federal approval, whichever is later.	**Page R9**: Identical Effective dates are identical, but Senate's effective date should be consistent with the rest of the Senate's effective dates.*	**Section 7 (254A.19. subd. 5)** makes a change in this section clarifying that a chemical use assessment may be conducted via telehealth.
8	**Rate requirements.** Amends § 254B.05, subd. 5. Modifies paragraph (f) to clarify terminology and add cross-reference to definition of telehealth. States that this section is effective January 1, 2022, or upon federal approval, whichever is later.	**Page R9:** Identical except for effective date. • House: January 1, 2022, or upon federal approval, whichever is later.* • Senate: July 1, 2021.	**Section 8 (254B.05, subd. 5)** makes changes within this section clarifying that chemical dependency services may be provided via telehealth, and that the use of telehealth must be medically appropriate and must meet the needs of the person being served. This section also strikes the requirement that the equipment and connection must comply with Medicare standards in effect at the time the service is provided.

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9	**Payment rates.** Amends § 256B.0621, subd. 10. Strikes a reference to a provision related to targeted case management and interactive video that is repealed in this article. States that this section is effective upon federal approval.	**Page R12:** Identical except for effective date. • House: January 1, 2022, or upon federal approval, whichever is later.* • Senate: July 1, 2021.	**Section 9 (256B.0621, subd. 10)** makes a conforming change.
		Page R12: Senate only	**Section 10 (256B.0622, subd. 7a)** permits a psychiatric provider as a member of an assertive community treatment (ACT) team to use telehealth with necessary to ensure the continuation of psychiatric and medication services availability for clients and to maintain requirements for psychiatric care staffing levels.
10	**Telehealth services.** Amends § 256B.0625, subd. 3b. Modifies MA coverage of telehealth services, to be consistent with changes made to telemedicine coverage requirements for health carriers that are reflected in § 62A.676. Under current law, MA coverage is generally consistent with § 62A.67 to 62A.672 (these sections are repealed in the bill and modified provisions are included in § 62A.676). The amendment to paragraph (a) eliminates the three visit per enrollee per calendar week limit on the provision of telehealth services and makes conforming changes. The amendment to paragraph (b) allows the commissioner to establish criteria that health care providers must attest to in order to demonstrate the safety or efficacy of a service delivered through telehealth (this is required of the commissioner under current law). Also makes conforming changes.	**Page R16:** Differences **Paragraph (a)**: Identical **Paragraph (b):** Identical	**Section 11 (256B.0625, subd. 3b)** makes modifications to this section updating the medical assistance coverage of services delivered by telehealth. The changes to current law are as follows: • **Paragraph (a)** removes the current coverage limitation of three telemedicine services per enrollee per calendar week. It also makes conforming changes in terminology. • **Paragraph (b)** permits the commissioner to establish criteria that a provider must attest to in order to demonstrate the safety and efficacy of delivering a particular service through telehealth. Under current law, the commissioner is required to establish such criteria.

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	The amendment to paragraph (c) makes conforming changes.	**Paragraph (c):** Identical	
		Senate Paragraph (d): Senate only	• **Paragraph (d)** authorizes telehealth visits provided through audio and visual communication to be used to satisfy the face-to-face requirement for reimbursement under methods that apply to FQHCs, rural health clinics, Indian health services, tribal clinics, and community behavioral health clinic if the service would have otherwise qualified for payment if performed in person.
		Senate Paragraph (e): Senate only	• **Paragraph (e)** permits a provider to document a client's verbal approval of the treatment plan or change to the treatment plan in lieu of the client's signature when mental health services or assessments are delivered through telehealth and are based on an individual treatment plan.
	The amendment to paragraph (d) replaces the definition of "telemedicine" with the definition of "telehealth." (This is the same definition as provided in § 62A.673, except that audio-only communication between a provider and patient is not covered if interactive visual and audio communication is specifically required.) The amendment to paragraph (d) also makes conforming changes in terminology. The amendment to paragraph (e) of current law incorporates the definition of "health care provider" used in § 62A.673 (this includes adding mental health practitioners), but expands the definition to also include other mental health and substance use disorder service providers. The amendment also incorporates the definitions of originating site, distant site, and store-and-forward transfer used in § 62A.673 into the MA statute. "Distant site" and "store-and-forward transfer" had not previously been defined in this section. Community paramedics and community health	**House Paragraph (d)/Senate Paragraph (f)**: • House includes audio-only communication in the definition of telehealth; Senate does not include audio-only communication, and specifically states that audio-only communication is not included. • House includes in the definition of health care provider "mental health case manager"; Senate does not. • House refers to "store and forward transfer"; Senate refers to "store and forward technology".	• **Paragraph (f)** modifies the definition of telehealth by updating the definition of health care provider and adds several additional professionals who can deliver services by telehealth. It also adds a cross reference to the definition of originating site, distant site, and store and forward technology.

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	workers are retained in the MA definition of "health care provider" (these providers are not included in the definition of health care provider used in § 62A.673). The amendment to paragraph (f) of current law makes a conforming change to the elimination of the three visit per week limit on the provision of telehealth services. States that the section is effective January 1, 2022, or upon federal approval, whichever is later.	**Effective Date:** • House: January 1, 2022, or upon federal approval, whichever is later.* • Senate: July 1, 2021.	
11	**Telemonitoring services.** Amends § 256B.0625, by adding subd. 3h. (a) States that MA covers telemonitoring services if the recipient: 1) has been diagnosed with and is receiving services for at least one specified chronic condition; 2) requires monitoring at least five times per week to manage the condition; 3) has had two or more emergency room or inpatient hospital stays within the last 12 months due to the chronic condition, or the recipient's health care provider has identified that telemonitoring would likely prevent admission or readmission to a hospital, emergency room, or nursing facility; 4) is capable of operating the monitoring device or equipment, or has a caregiver willing and able to assist; and 5) resides in a setting suitable for telemonitoring and not in a setting with health care staff on site.	**Page R18:** Differences House only requirements for telemonitoring services to be covered: • Recipient has been diagnosed and is receiving services for at least one of the following chronic conditions: hypertension, cancer, congestive heart failure, chronic obstructive pulmonary disease, asthma, or diabetes. • Requires at least five times per week monitoring, as ordered by the provider. • Has had two or more emergency room or in-patient hospitalization stays within the last 12 months or the recipient's provider has identified that telemonitoring would likely prevent admission or readmission to hospital, emergency room, or nursing facility.	**Section 12 (256B.0625, subd. 3h)** requires medical assistance to cover telemonitoring services if (1) the service is medically appropriate based on the recipient's medical condition or status; (2) the recipient's 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 device or equipment or has a caregiver who can operate the 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.

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	(b) Provides a definition of "telemonitoring services." The definition specifies the provider types that can assess and monitor the data transmitted by telemonitoring. States that this section is effective January 1, 2022.	Senate only requirements: • Telemonitoring is medically appropriate based on condition and status. • Recipient's provider has identified that telemonitoring would likely prevent admission or readmission to hospital, emergency room, or nursing facility. Section otherwise the same with technical differences (depends on policy decisions) **Effective Date:** • House: January 1, 2022* • Senate: July 1, 2021	
12	**Medication therapy management services.** Amends §256B.0625, subd. 13h. The amendment to paragraph (b) eliminates the requirement that a pharmacist practice in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process, in order to be eligible for MA reimbursement for medication therapy management services. The amendment to paragraph (c) eliminates a reference to the commissioner establishing contact requirements between the pharmacist and recipient.	**Page R19:** Identical except for effective dates. • House: January 1, 2022* • Senate: July 1, 2021	**Section 13 (256B.0625, subd. 13h)** expands the coverage of medication therapy management (MTM) services that are authorized to be delivered through telehealth. It removes the requirement that services may be delivered through telehealth only if there are no pharmacists practicing within a reasonable geographic distance from the patient. It also removes the requirement that the pharmacist practice within an ambulatory setting and permits the delivery of services by telehealth to occur within the patient's residence.

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	The amendment to paragraph (d) states that medication therapy management services may be provided by telehealth and delivered in a patient's residence. Strikes current law which provides coverage for the service when provided through two-way interactive video if there are no pharmacists practicing within a reasonable geographic distance. Also strikes language limiting reimbursement to situations in which both the pharmacist and patient are located in an ambulatory care setting, and prohibiting services from being transmitted into the patient's residence. Strikes paragraph (e), which specifies requirements for the delivery of medication therapy management services into a patient's residence through secure interactive video. States that this section is effective January 1, 2022.		
13	**Mental health case management.** Amends § 256B.0625, subd. 20. Allows medical assistance and MinnesotaCare payment for mental health case management provided through contact by interactive video that meets statutory requirements. States that this section is effective upon federal approval.	**Page R21:** minor differences House: refers to face-to-face contact or contact by interactive video. Senate: refers to face-to-face contact either in-person or contact by interactive video. **Effective Date:** • House: upon federal approval* • Senate: July 1, 2021	**Section 14 (256B.0625, subd. 20)** makes a change to this subdivision clarifying that mental health case management services may be provided as face-to-face contact either in-person or through interactive video.

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14	**Targeted case management face-to-face contact through interactive video.** Amends § 256B.0625, subd. 20b. Allows the face-to-face contact requirements for mental health targeted case management to be met using interactive video, if this is in the best interests of the person and deemed appropriate by the recipient or legal guardian and the case management provider. Makes various clarifying and conforming changes. Also prohibits interactive video from being used to meet face-to-face contact requirements for children who are in out-of-home placement or receiving case management services for child protection reasons. Provides a definition of interactive video. States that this section is effective upon federal approval.	**Page R24:** minor differences • **Paragraphs (a) and (c):** House refers to "face-to-face contact through interactive video"; Senate refers to "by interactive video". (Staff recommends House) • **Paragraph (c):** House refers to "via interactive video"; Senate refers to "by interactive video". (Staff recommends Senate) • **Paragraph (d):** House uses "purpose"; Senate uses "purposes". (Staff recommends House) • **Paragraph (d):** House refers to "contacts"; Senate refers to "contact/service". (Staff recommends House) • **Paragraph (d):** House refers to "interactive services and records evidencing"; Senate refers to "services delivered by interactive video and records stating". (Staff recommends Senate) • **Paragraph (e):** technical differences. (Staff recommends House) • **Paragraph (f):** technical differences. (Staff recommends Senate) **Effective Date:** • House: upon federal approval* • Senate: July 1, 2021	**Section 15 (256B.0625, subd 20b)** modifies this subdivision to create a subdivision that outlines the requirements for proved targeted case management services by interactive video. This section permits face-to-face contact for targeted case management services to be provided by interactive video if it is in the best interest of the person and it is deemed appropriate by the person or the person's legal representative and the case management provider. It also removes the limits as to where a person must reside in order to receive case management services by interactive video. It prohibits the use of interactive video when a face-to-face contact is required for children receiving case management services for child protection reasons or who are in out-of-home placements. It also defines interactive video.
15	**Mental health telehealth.** Amends § 256B.0625, subd. 46. Clarifies terminology and adds a cross-reference to the definition of telehealth.	**Page R25**: Identical except for effective date. • House: January 1, 2022, or upon federal approval*	**Section 16 (256B.0625, subd. 46)** makes a change to this subdivision clarifying that mental health services that are required to be provided as direct face to face services may be provided via telehealth. This section also strikes the

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16	**Definitions.** Amends § 256B.0911, subd. 1a. Modifies the definition of "long-term care consultation services" by removing language requiring long-term care consultation assessments to be face-to-face.	**Page R26**: House only	
17	**Assessment and support planning.** Amends § 256B.0911, subd. 3a. Adds paragraph (q), which requires all long-term care consultation assessments to be face-to-face unless the assessment is a reassessment that meets specified requirements such as: 1) allowing remote reassessments to be conducted by interactive video or telephone for services provided under alternative care, the elderly waiver, the developmental disabilities waiver, the CADI waiver, and the BI waiver; 2) allowing remote assessments to substitute for two consecutive reassessments if followed by a face-to-face reassessment; and 3) allowing a remote assessment if the person being assessed, the person's legal representative, and the lead agency case manager all agree that a remote reassessment is appropriate. Gives the person being reassessed, or the person's legal representative, the right to refuse a remote reassessment at any time. Requires a certified assessor to suspend a remote reassessment and schedule a face-to-face reassessment if the certified assessor determines that a remote reassessment is	**Page R28**: House only	

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	inappropriate. Applies all other requirements of a face-to-face reassessment to a remote reassessment. Also makes technical and conforming changes.		
18	**Long-term care reassessments and community support plan updates.** Amends § 256B.0911, subd 3f. Makes conforming changes in the section of statutes governing long-term care consultation services.	**Page R32:** House only	
19	**Preadmission screening of individuals under 65 years of age.** Amends § 256B.0911, subd. 4d. Makes conforming changes in the section of statutes governing long-term care consultation services. Also specifies criteria for remote assessments. Gives the person being reassessed, or the person's legal representative, the right to refuse a remote assessment at any time.	**Page R33**: House only	
20	**Payment for targeted case management.** Amends § 256B.0924, subd. 6. Allows for medical assistance and MinnesotaCare payment for targeted management provided thought contact by interactive video that meets statutory requirements. States that this section is effective upon federal approval.	**Page R34**: minor differences • House refers to face-to-face contact or contact by interactive video; Senate refers to face-to-face contact either in-person or by interactive video. • Technical difference (Staff recommends Senate) **Effective Date:** • House: effective upon federal approval* • Senate: July 1, 2021	**Section 17 (256B.0924, subd. 6)** specifies that for payment for targeted case management, a 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.

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21	**Medical assistance reimbursement of case management services.** Amends § 256B.094, subd. 6. Allows for case management face-to-face contacts for clients or children placed more than 60 miles from the county or tribal boundaries to occur via interactive video for up to two consecutive contacts following each in-person contact. States that this section is effective upon federal approval.	**Page R36**: minor differences • House adds "interactive video" and refers to "face-to-face contact or contact by interactive video". • Senate includes a clause (3) that specifies that face-to-face contact must be in person and if a child is receiving case management services for child protection reasons or is in out-of-home placement. • House specifies that face-to-face contact may be conducted using interactive video for up to two consecutive contacts following each in-person contact. • Technical differences (staff recommends combination of House/Senate) **Effective Date:** • House: effective upon federal approval* • Senate: July 1, 2021	**Section 18 (256B.094, subd. 6)** specifies that for a child receiving case management services for child protection reasons or who is in out-of-home placement face-to-face contact must be through in-person contact.
		Page R38: Senate only	**Section 19 (256B.0943, subd. 1)** changes terminology within this section (children's therapeutic services) from telemedicine to telehealth and defines telehealth by referencing section 256B.0625, subdivision 3b.
		Page R41: Senate only	**Section 20 (256B.0947, subd. 6)** specifies intensive nonresidential rehabilitative mental health services provided by a psychiatric provide may be provided through telehealth when necessary to prevent disruption in client services or to maintain the required psychiatric staffing levels.
		Page R43: Senate only	**Section 21 (256B.0949, subd. 13)** specifies that travel time is allowable billing for early intensive developmental and

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			behavioral intervention (IEDBI) benefits within providing in-person services. Changes terminology from telemedicine to telehealth.
22	**Assessment and reassessment.** Amends § 256B.49, subd. 14. Removes language requiring assessments to be face-to-face in the section of statutes governing home and community-based service waivers for persons with disabilities.	**Page R45**: House only	
		Page R45: Senate only	**Article 9, section 11 (256J.08, subdivision 21)** permits applicants for the Minnesota Family Investment Program (MFIP) to submit initial applications online or via telephone.
23	**Submitting application form.** Amends § 256J.09, subd. 3. Modifies county agency duties related to the information the agency must provide to potential MFIP applicants by requiring the agency to inform a person that the application may be submitted by telephone or through Internet telepresence and the interview may be conducted by telephone. Makes technical and conforming changes.	**Page R45:** minor difference • Senate requires a "signed written application"; House requires a "written application"	**Article 9, section 12 (256J.09, subdivision 3)** makes conforming changes; requires county agencies to inform applicants for MFIP submitting an initial application online or via telephone that the county agency must receive the applicant's signed written application within 30 days of submitting the initial application; and permits applicant interviews to be conducted by telephone.
24	**County agency to provide orientation.** Amends § 256J.45, subd. 1. Removes the requirement that the MFIP orientation be provided face-to-face.	**Page R47:** identical	**Article 9, section 15 (256J.45, subdivision 1)** removes the requirement that when the county agency provides an orientation to an MFIP caregiver of a minor child, that the orientation be done face-to-face.

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		Page R47: Senate only	**Article 9, section 17 (256J.95, subdivision 5)** authorizes assistance to begin on the date that an applicant for the Diversionary Work Program (DWP) submits an initial application online or via telephone and requires county agencies to inform applicants submitting an initial application online or via telephone that the county agency must receive the applicant's signed written application within 30 days of submitting the initial application.
25	**Nursing facility level of care determination required.** Amends § 256S.05, subd. 2. Makes a conforming change in the chapter of statutes governing the elderly waiver related to the changes in long-term care consultation assessments.	**Page R48**: House only	
		Page R48: Senate only	**Section 22 [Extension of COVID human services program modification]** extends until June 30, 2023, the commissioner of human services modifications and waivers that involve expanding access to telemedicine services; allowing telemedicine alternatives to school linked mental health services; allowing the use of phone or video for targeted case management visits; extending telemedicine in health care, mental health and substance use disorder settings; and permitting comprehensive assessments to be completed by telephone or video communication and allowing the counselor, recovery peer or treatment coordinator to provide treatment services from their home by telephone or video communications to a client in their home.
		Page R48: Senate only	**Section 23 [Expanding telehealth delivery options]** requires the commissioner of human services to study the viability of the use of audio only communication as a permitted option for the delivery of services delivered through telehealth and report any

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			recommendations to the legislature by December 15, 2022.
26	**Study of telehealth.** (a) Requires the commissioner of health, in consultation with the commissioners of human services and commerce, to study the impact of telehealth payment methodologies and expansion under this act on the coverage and provision of health care services in public and private sector health coverage. Requires the study to review specified topics. (b) Requires the commissioner to consult with stakeholders and communities, and allows the commissioner to use data from the all-payer claims database. Requires the commissioner to report to the legislature by February 15, 2023.	**Page R49:** Differences **Paragraph (a):** • House includes DHS and Commerce; Senate only includes DHS. • House refers to "health care services"; Senate refers to "telehealth services". • House requires the study to "also review and make recommendations to"; Senate requires the study to "review". • House refers to the Minnesota Telehealth Act (section 1 only); Senate to "this act" (all the sections in the act (article) • **Clause (3):** House includes the use of audio-only communication supporting equitable access; Senate includes the short- and long-term impacts of access to and the availability of in-person care and specialty care. • **Clause (4):** House includes whether the use of telehealth and increased access improves health outcomes and for which services and populations; Senate includes the criteria used for determining whether services delivered by telehealth are medically appropriate to conditions and the needs of the patient. • **Clause (5):** House includes the effects of payment parity on health care costs, premiums, and outcomes; Senate included methods used to ensure that patients can choose not to receive a service by telehealth.	**Section 24 [Study of telehealth]** requires the commissioner of health in consultation with the commissioner of human services, to study the impact of telehealth payment methodologies and delivery expansion on the coverage and provision of services delivered through telehealth under public health care programs and under private health insurance and submit the report findings to the legislature by February 15, 2024.

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		• **Clause (6):** Senate only, includes making recommendations on interstate licensing options. **Minor differences in Paragraph (b):** one technical difference (staff recommends House). • **Paragraph (b)** has different committees receiving the report: House sites legislative committees with jurisdiction over health care; Senate sites jurisdiction over health and human services. • **Paragraph (b)** has difference in when the report is due: House – February 15, 2023; Senate – February 15, 2024.	
27	**Expiration date.** Provides that sections 1 to 15, 20, and 21 expire July 1, 2023. Exempts the definition of "originating site" from expiration.	**Page R50**: House only	
		Page R50: Senate only	**Section 25 [Task force on public-private telepresence strategy]** establishes a task force to: (1) explore opportunities for improving health care service delivery through the use of a common interoperable person-centered telepresence platform; (2) review and coordinate state and local innovation initiatives and investments designed to leverage telepresence connectivity and collaborations; (3) determine standards for a single interoperable telepresence platform; (4) determine statewide capabilities for a single interoperable telepresence platform; (5) identify barriers to providing telepresence technology;

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			(6) identify and make recommendations for governance that assures person-centered responsiveness; (7) identify how the business model can be innovated to provide incentive for ongoing innovation; (8) identify criteria for suggested deliverables; (9) identify sustainable financial support for a single telepresence platform; (10) identify the benefits to partners in the private sector, state, political subdivisions, tribal governments, and constituents in using a common person-centered telepresence platform for delivering behavioral services; and (11) consult with members of communities likely to use a common person-centered telepresence platform. **Requires the task force to provide a report to the legislature by January 15, 2022.**
28	**Revisor instruction.** Directs the revisor to substitute the term "telehealth" for "telemedicine" in Minnesota Statutes and Minnesota Rules, and to substitute "section 62A.673" whenever references to sections 62A.67, 62A.671, and 62A.672 appear.	**Page R52:** minor differences (staff recommends Senate/House combination)	**Section 26 (Revisor Instruction)** instructs the revisor to substitute the term "telemedicine" with "telehealth" and to correct necessary cross references.
29	**Repealer.** (a) Repeals sections 62A.67, 62A.671, and 62A.672 (current law governing coverage of telemedicine services by health carriers) January 1, 2022, and revives and reenacts these sections July 1, 2023. (b) Repeals sections 256B.0956 (county contracts for mental health case management) and 256B.0924, subd. 4a (targeted case	**Page R53** The sections being repealed are the same but the effective dates of the repealers are different, and the House reenacts the repealed sections, effective July 1, 2023. (Sections that are reenacted are indicated with an *)	**Section 27 (Repealer)** repeals the current telemedicine statutes that are being replaced by the new telehealth sections in 62A.673 and 256.0596, and repeals section 256B.0924, subd. 4a (targeted case management through interactive video).

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	management through interactive video), effective upon federal approval and revives and reenacts these sections July 1, 2023.	**Repealer Effective Date:** • House: Paragraph (a) – January 1, 2022; Paragraph (b) – upon federal approval • Senate: July 1, 2021	