Senate Counsel, Research, and Fiscal Analysis

Tom Bottern, Director

Minnesota Senate Building
95 University Ave. W. Suite 3300
ST. PAUL, MN 55155-1800
(651) 296-4791
www.senate.mn/scrfa

Senate

State of Minnesota

S.F. No. 1160 – Modifications to Telehealth Coverage (6th Engrossment)

Author: Senator Julie A. Rosen

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801)

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S.F. 1160 modifies coverage for services and consultations delivered through telehealth under private health plan coverage and public health care coverage. **S.F. 1160** modifies telehealth coverage by including the delivery of health care services and consultations when using interactive audio and visual or audio only communication when the patient and health care provider are in different locations. **S.F. 1160** also makes conforming changes in a number of statutes consistent with these changes.

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 transfer; 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 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 consist solely of an email or fax.

- Adds a definition for telemonitoring services.

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.
- **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.

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 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, 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 service can be met using audio only communication.

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.

Section 2 (147.033) makes conforming changes in this section by changing terminology and cross references.

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.

Sections 4 to 6 (245G.01, subd. 13; 245G.01, subd. 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.

Section 7 (254A.19. subd. 5) makes a change in this section clarifying that a chemical use assessment may be conducted via telehealth.

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.

Section 9 (256B.0621, subd. 10) makes a conforming change.

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.

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.
- **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.
- **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.
- **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 transfer.

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.

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.

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.

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.

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 requirement that the equipment and connection must comply with Medicare standards in effect at the time the service is provided.

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.

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.

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.

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.

Section 21 (256B.0949, subd. 13) specifies that travel time is allowable billing for early intensive developmental and behavioral intervention (IEDBI) benefits withn providing in-person services. Changes terminology from telemedicine to telehealth.

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.

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 recommendations to the legislature by December 15, 2022.

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.

Section 25 [Task force on public-privater 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;
(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; and
(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.

Requires the task force to provide a report to the legislature by January 15, 2022.

Section 26 [Appropriation] provides an appropriation to the legislative coordinating commission to administer the task force on a public/private telepresence strategy.

Section 27 is a revisor instruction instructing the revisor to substitute the term “telemedicine” with “telehealth” and to correct necessary cross references.

Section 28 repeals the current telemedicine statutes that are being replaced by the new telehealth section in 62A.673, and repeals section 256B.0924, subd. 4a (targeted case management through interactive video).
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